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REFORM OF MEDICARE CAPITAL COSTS PAYMENTS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

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NOVEMBER 8, 1985

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REFORM OF MEDICARE CAPITAL PAYMENTS

FRIDAY, NOVEMBER 8, 1985

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, DC.

The committee met, pursuant to notice, at 9:15 a.m. in room SD-215, Dirksen Senate Office Building, the Honorable David Durenberger (chairman) presiding.

Present: Senators Durenberger and Bradley.

[The press release announcing the hearing and a background paper on the hospital capital cost reimbursement under the Medicare Program follows:]

[Press Release No. 85-081]

PROPOSAL FOR REFORM OF MEDICARE CAPITAL PAYMENTS SET FOR FINANCE SUBCOMMITTEE HEARING NOVEMBER 8

The Senate Committee on Finance's Subcommittee on Health has scheduled a November 8 hearing to receive a Department of Health and Human Services (HHS) report on proposed reform of the Federal hospital insurance program's (Medicare Part A) method of paying for capital costs, Chairman Bob Packwood (R-Oregon) said today.

Senator Packwood said his HHS report was requested under a provision of the Social Security Amendments of 1983.

The Subcommittee hearing is scheduled to begin at 9:15 a.m., Friday, November 8, 1985, in Room SD-215 of the Dirksen Senate Office Building.

The report will outline HHS proposals for a new system of Medicare payments to the nation's hospitals to fund capital costs, Senator Packwood said. President Reagan's Cabinet Council on Domestic Policy already has reviewed the proposal, which must win Congressional approval before it can be implemented.

Senator Packwood said Senator David Durenberger (R-Minnesota), Chairman of the Subcommittee on Health, would preside at the November 8 hearing.

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HOSPITAL CAPITAL COST REIMBURSEMENT UNDER THE MEDICARE PROGRAM

Prepared for the use of the
Senate Committee on Finance

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Education and Public Welfare Division
November 5, 1985

HOSPITAL CAPITAL COST REIMBURSEMENT UNDER THE MEDICARE PROGRAM

INTRODUCTION

From 1966 until October 1983, payments for hospital services under the Medicare program were made on the basis of certain allowed or "reasonable" costs actually incurred by participating hospitals in providing care to Medicare beneficiaries. In 1983, however, Congress enacted a new system for paying hospitals on the basis of a prospectively determined specific amount per case, according to individual patient diagnoses. 1/ The purpose of the change in reimbursement policy was to create incentives for hospitals to improve controls over spending and resource use in serving Medicare hospital inpatients.

Not all of the expenses previously reimbursed by Medicare on a reasonable cost basis, however, were incorporated into the prospective payment scheme. For example, Congress excluded certain capital-related costs from the prospective payment system until October 1, 1986. Until then, these capital costs will continue to be reimbursed on a reasonable cost basis. Congress directed the Secretary of Health and Human Services (HHS) to study and report to Congress (by October 20, 1984) on methods and proposals for including capital-related costs in the prospective payment system. However, the Secretary has not yet submitted the report.

1/ P.L. 98-21, the Social Security Amendments of 1983. For a discussion of the elements of Medicare's prospective payment system, see CRS Issue Brief IB83171, "Medicare: Prospective Payments for Inpatient Hospital Services."

The purpose of this paper is to review current policy regarding payments to hospitals for capital-related costs under the Medicare program. The discussion is organized in four parts. Section I provides background information on the nature of capital-related costs and historical trends in methods of financing hospital capital expenditures. Current payment policy under Medicare for capital-related costs is described in Section II including the treatment of each of the major components of such costs. Section III summarizes major reasons for the widespread interest in changing current policy and the key issues related to the design of an alternative policy. Finally, Section IV describes legislative proposals introduced in the 99th Congress which would include payments for capital-related costs in the hospital prospective payment system.

I. BACKGROUND

This section provides a brief conceptual review of the capital-related costs that may arise when hospitals acquire durable assets such as buildings and equipment. This review describes all of the major elements of capital-related costs including rent, depreciation and interest costs and the costs of equity capital, insurance and property taxes. This discussion is followed by a summary of trends in the methods hospitals have used to finance capital expenditures over the past four decades.

A. Major Elements of Capital Related Costs

Hospitals use capital assets such as land, buildings and equipment, together with other resources such as labor and supplies, to produce patient care services. Capital assets, however, generally differ from other resources in terms of their relative durability and cost. A new building, for example, may be expected to have an economically useful life of 30 years or more. In addition, because many capital assets such as buildings or major items of equipment are very costly, they are rarely purchased outright. Instead, the cost of acquiring capital assets is usually financed over a period of years by a combination of accumulated earnings (equity), borrowed funds and, in the case of proprietary (i.e., for-profit) hospitals, by the sale of stock (a second source of equity funds). Alternatively, the use of capital assets may be obtained by lease arrangements rather than purchase.

When hospitals acquire the use of capital assets through ownership or lease transactions, certain capital-related costs are incurred. The particular capital-related costs incurred generally depend on whether the assets are acquired by lease or purchase and, if purchased, on how the purchase is financed. Thus, if a hospital leases such assets as buildings or equipment, it must pay the related rental costs over the life of the rental agreement. If the same depreciable assets (excluding land, which cannot be used up or "depreciated") are purchased rather than leased, then depreciation expenses are generated. Depreciation expenses represent the portion of the cost or value of a durable asset that is used up each year during the useful life of the asset. This concept is based on the fact that although the full initial cost of a capital asset is incurred in the year in which it is purchased, the value of the asset is not fully used up in that year. Instead, a portion of the value of the asset (e.g., a CAT scanner) is used up during each year of its economically useful lifetime, either because it wears out physically or because it becomes obsolescent over time. Thus, depreciation serves to spread the cost or value of the asset over the years in which it is actually used up.

Other elements of capital-related costs depend on the methods of financing adopted in purchasing capital assets. If the purchase is financed by borrowed funds, then interest costs are incurred for the use of those funds during the period of the loan. Costs also are incurred if the purchase is financed by the use of equity funds, i.e., accumulated earnings or the sale of stock. In this case, however, the cost is implicit rather than explicit since no actual cash expenditures analogous to interest payments occur. This cost of equity capital may be thought of as the loss of potential earnings that could have been obtained over the lifetime of the purchased assets if these funds had been invested in some other use. This element of capital-related cost rests on the recognition that all funds from any source have alternative uses and something is given up (i.e., there is a cost) when one particular use is chosen. Thus, the cost of financing capital assets with equity funds also should be taken into account.

In addition to these costs, capital-related costs include the cost of insurance to protect the assets against loss and property taxes imposed on land or depreciable assets.

These capital-related costs are generated directly by hospital transactions involving the acquisition and financing of capital assets. In order to measure or account for the full cost of producing patient care services, all of these costs must be included along with the hospital's operating costs to arrive at an accurate total. Historically, the extent to which traditional accounting methods and measurement techniques have captured the full cost of capital has always been somewhat controversial. Similar controversy also has surrounded the issue of whether and to what extent each element of capital-related cost should be reimbursed by the major purchasers of hospital care (e.g., Medicare, Medicaid, Blue Cross plans, commercial insurers, etc.).

The capital payment policies of the major payors for hospital care are important for three reasons. First, these policies affect the hospital's ability to recover its full cost of providing services and, therefore, its long-term financial stability. Second, such policies may create incentives for hospitals to over or underinvest in capital assets relative to other productive resources, leading to reduced economic efficiency and higher overall costs for producing services. Finally, capital payment policies may create incentives for hospitals to choose one method of financing capital expenditures over another (e.g., debt over equity), which may lead to financial instability, reduced access to capital financing and higher costs for services over the long term.

Trends in the financing of hospital capital expenditures over the last 40 years reflect the influence of the payment policies adopted by the major purchasers of care as well as other factors such as the growth of public and private health insurance programs, government tax and other policies, and trends in general economic conditions such as inflation. These trends are described in the next section.

B. Financing Hospital Capital Needs--Brief History

The funds needed to acquire capital assets such as land, buildings, and equipment, or to renovate existing buildings and equipment, represent a hospital's "capital needs." As noted above, the capital needs of most economic enterprises are generally met through a combination of debt financing (i.e., borrowing) and equity financing (i.e., retained earnings or the sale of stock). For hospitals, however, philanthropy and government subsidy have also been important sources for meeting capital needs.

Hospitals have not ordinarily been able to generate the earnings necessary to finance their capital needs. Instead, financing for capital purposes has usually come from other sources. For example, until World War II, the major source of hospital capital financing was philanthropy--e.g., donated funds from individuals, religious groups or local community subscription. 2/ After the War, public financing in the form of Federal grants and loans under the Hill-Burton program became an increasingly important additional source of capital financing for hospital plant construction and renovation for many institutions. 3/

2/ It has been estimated that about two-thirds of capital provided the industry before World War II came from philanthropic sources.

3/ Nearly 4,000 hospitals received about $4 billion in grants, while 300 facilities received an additional $1.9 billion in loans and loan guarantees, under the Hill-Burton program before it ceased to exist as a source of capital in the 1970's.

The end of the War also marked the beginning of dramatic growth in private health insurance protection, provided through the workplace, against the costs of hospital care for workers and their dependents. This development was important in the history of capital financing in the hospital sector because the certainty of payments from such sources increased the stability of hospitals' cash flow and ensured that revenues would be available to repay borrowed principal and interest obligations. Thus, increased financial stability enhanced opportunities to use borrowed funds as a source to finance capital needs.

The enactment of Medicare and Medicaid in the mid-1960's also had major effects on the relative importance of different sources of hospital capital financing. First, as with private insurance coverage, Medicare and Medicaid further improved the general financial stability of the hospital industry. Before creation of these two government programs, the elderly and the poor--both important segments of the caseloads of many community hospitals--were often unable to pay for the hospital services they received. Medicare and Medicaid helped to reduce both the free care and bad debt burdens represented by each of these groups for many institutions.

Second, Congress decided to pay for care provided to the aged and poor under these new programs on the basis of the actual costs incurred, not on the basis of the prices charged by the hospitals for such services. This decision to opt for cost-based reimbursement further encouraged borrowing as a source of capital financing because the Government included both depreciation expense and interest expense on borrowed funds in its definition of reimbursable costs. 4/

4/ These and the other capital-related expenses paid for on a cost basis under Medicare are discussed in detail in the next section of this report.

In addition, these developments encouraged lenders to make funds available to hospitals because the certainty of payment of depreciation and interest significantly reduced the risk that borrowed funds would not be repaid. Debt financing was also encouraged because cost reimbursement generally reduces a hospital's ability to accumulate net earnings (revenues in excess of costs) from a cost-based payer. This occurs because under cost reimbursement, payments (revenues) to the hospital are set approximately equal to its incurred costs. Thus, efforts to increase retained earnings by lowering costs are met by equal reductions in payments. As a result, the potential to obtain net earnings from cost-based reimbursement is essentially eliminated. Reimbursement of depreciation expense also made borrowing an attractive method of financing capital needs. In the early years of debt repayment, cash inflow for depreciation often exceeds cash outflow for the repayment of principal (known as amortization), thereby generating "excess" funds that can be used for any number of noncapital-related purposes. 5/

Other factors, of course, also contributed to the steadily increasing use of debt as the principal source of funds to meet capital needs for the hospital industry during the last two decades. These included the decline of philanthropic contributions, the development of mortgage loan insurance to facilitate hospital plant and equipment purchases, governmental policies that expanded and encouraged the issuance and use of tax-exempt debt instruments to finance capital needs, and long periods of persistent and sometimes severe inflation. During

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5/ Amortization is the repayment of loan principal on an installment basis. Under a level loan repayment schedule (e.g., constant payment per month over the life of the loan), the amount of the installment payment representing principal is, at the beginning of an amortization period, usually quite small and usually less than the depreciation amounts reimbursed by Medicare during the initial years of repayment of the loan.

periods of rapid inflation, for example, hospitals found that loans could be paid back in the future with dollars cheaper than those that had been borrowed.

The impact of these influences on the sources of capital financing has been dramatic. One estimate for 1962 indicated that only about 12 percent of new hospital plant was financed by borrowing. 6/ By 1969, about 40 percent of the construction costs of nonprofit hospitals and more than 60 percent for investor-owned institutions were financed from debt sources. 7/ Debt is now by far the most important source of capital financing for the hospital industry: 8/

6/ J.B. Silvers, "How Do Limits to Debt Financing Affect Your Hospital's Financial Status?" Hospital Financial Management, February 1975, p. 32.

7/ Irwin Wolkstein, "The Impact of Legislation on Capital Development for Health Facilities," Health Care Capital: Competition and Control. Ballinger Publishing Company, Cambridge, Massachusetts, 1978.

8/ Survey of Sources of Funding for Hospital Construction, American Hospital Association. The hospital industry borrows funds for more than construction. For example, about 60-65 percent of the debt-raised capital in 1981 went for project costs, including construction expenses, equipment acquisitions and architectural and engineering fees. The balance of the borrowings was used to refinance existing debt, for debt service reserves and capitalization of interest funds, and for other purposes.

Sources of Hospital Construction Funding, 1973-1981

Funding Sources	1973	1977	1981
Government grants & appropriations	20.8%	17.2%	12.1%
Philanthropy	9.9	7.1	3.9
Hospital reserves a/	14.9	13.2	14.9
Debt	54.4	62.5	69.1

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a/ Reserves include funded depreciation, sale of replaced assets and equity for investor-owned hospitals.

II. MEDICARE'S PRESENT CAPITAL PAYMENT RULES

A. General

Present law provides that certain capital-related costs incurred by hospitals in providing inpatient services to Medicare beneficiaries are reimbursable on a reasonable cost basis. Under current law, these costs are excluded from Medicare's prospective payment system for inpatient hospital services until October 1, 1986.

Current regulations define the capital-related costs that the Secretary of Health and Human Services recognizes as allowable for reimbursement purposes. Such costs must be reasonable and related to the provision of patient care. Reasonable costs include all necessary and proper expenses incurred in rendering services to beneficiaries. To be allowed, costs cannot exceed what a prudent and cost-conscious buyer would pay for a given item or service.

Medicare's payments to hospitals for capital-related costs are based on the share of the hospitals' total capital costs that is attributable to services provided to program beneficiaries. Thus, the allowable capital costs of each participating hospital are apportioned or divided between Medicare program beneficiaries and the other patients using the hospital. This is accomplished through accounting methods which measure the use of the hospital's resources by Medicare beneficiaries relative to the total hospital resources used by all patients served. Once Medicare's share is determined, such amounts are paid to the hospital in addition to any payments for inpatient services under the prospective payment system. Other additional payments are made for the costs of medical education, kidney acquisition and services of non-physician anesthetists.

B. Major Elements of Capital Cost Reimbursed by Medicare

Among the major elements of capital cost currently reimbursable under Medicare are: 9/

1. Depreciation. Medicare recognizes depreciation as an element of capital cost payable by the program. Depreciation expenses are amounts which represent the portion of an asset's cost that is charged-off to a particular period of operation, such as an accounting or reporting period (usually a year). In the case of hospitals, depreciable assets include: buildings, building equipment, major movable equipment, minor equipment, land improvements and leasehold improvements made by a lessee. 10/

Depreciation accounting is a system of accounting which prorates the acquisition cost or other basic value of tangible assets, less salvage value (if any), over the "useful lives" of such assets. 11/ The measurement of periodic depreciation expenses or charges is dependent on three factors: the depreciation base, the "useful life" of the asset and the depreciation method.

Under Medicare, depreciation is based upon the "historical cost" of the acquired assets. Historical cost is the cost incurred by the present owner in

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9/ In addition, the regulations define capital-related costs to include a number of other minor items, such as certain betterments and improvements, the costs of minor equipment that are capitalized rather than charged off to expense, some insurance costs of depreciable assets used for patient care, and taxes on land or depreciable assets used for patient care.

10/ Land is not a depreciable asset.

11/ Salvage value is the estimated amount expected to be realized upon sale or other disposition of a depreciable asset at the end of its useful life.

acquiring the assets. The estimated useful life of an asset is its expected useful life to the hospital, not necessarily the asset's inherent useful life or physical life. In general, the estimated useful lives developed by the American Hospital Association (AHA) are used by hospitals and accepted by the Medicare program for determining depreciation. [12] For assets acquired in 1983 and thereafter, the AHA's Estimated Useful Lives of Depreciable Hospital Assets (1983 edition) is used as a guide for such purposes. An earlier (1978) edition is used for assets acquired in 1982. The AHA's 1973 Chart of Accounts is used in connection with assets acquired before 1982.

Since August 1, 1970, only the "straight-line" depreciation method has generally been allowed for prorating the historical cost of an asset under Medicare. In this method, the historical cost of an asset (minus any salvage value) is charged in equal amounts per year over the useful life of the asset. Thus, a building with a historical cost of $25 million (with no salvage value) and an estimated useful life of 25 years would be depreciated at $1 million per year. Medicare does not require the funding of depreciation; that is, the hospital is not required to set aside cash (in an amount equal to allowed depreciation) for the replacement of depreciated assets, buildings or equipment.

The Economic Recovery Tax Act of 1981 (P.L. 97-34) made a number of changes in the calculation of depreciation for income tax purposes. However, the law excludes Medicare (and other programs administered by the Secretary of Health and Human Services) from the new depreciation rules for purposes of determining cost reimbursement under the program.

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[12] For example, the AHA guidelines show a useful life of no more than 40 years for buildings. Fixed assets in the buildings, such as elevators, heating and air conditioning, plumbing, etc., have suggested useful lives of between 10 and 20 years.

2. Rental Expense. Rental expenses including license and royalty fees are recognized by the Medicare program as capital-related costs if these expenses are related to the use of assets that would be depreciable if they were owned by the hospital. Thus, rental expenses for the use of capital assets such as buildings or equipment that are reasonably related to patient care would be allowable capital-related costs. Under certain conditions, however, reasonable and allowable rental expenses may be limited to the amount of capital-related cost (e.g., for depreciation, interest expense and insurance) the hospital would have incurred if it owned the assets instead. This limitation may apply, for example, in certain "sale and lease-back" arrangements or where a rental agreement provides for rental charges that appear excessive given the rental charges for comparable assets in the area.

3. Interest Expense. Necessary and proper interest expense on capital indebtedness is included as an allowable capital-related cost under Medicare. Capital indebtedness represents long-term loans in which the funds are used for meeting capital needs, i.e., acquiring or improving facilities and equipment. Although interest expenses related to short-term borrowing (e.g., for working capital needs) are an allowable cost, they are generally treated as operating costs and, therefore, not included in capital-related costs.

To be recognized as a Medicare allowable cost, interest must be incurred on funds borrowed to satisfy the financial needs of the hospital and must be for a purpose reasonably related to patient care. The rate of interest must not exceed what a prudent borrower would have had to pay in the money market in an arms-length transaction. The interest must be paid to a lender not related through control, ownership, or personal relationship to the borrowing organization.

Generally, allowable interest expenses are offset (i.e., reduced) by investment income, except where such income arises from investment of gifts, grants, endowments, funded depreciation, pension funds, and deferred compensation funds.

4. Return on Equity Capital of Proprietary Hospitals. A specified return on equity (or owner) capital invested and used in providing patient care is an allowable cost for proprietary, or for-profit, hospitals under Medicare. Equity capital is the net worth of a hospital (assets minus liabilities, excluding those assets and liabilities not related to patient care). Specifically, equity capital includes: (1) the net investment in plant, property and equipment (net of accumulated depreciation and long term debt) related to patient care, plus deposited funds required in connection with leases; and (2) net working capital maintained for necessary and proper operation of patient care facilities.

The base amount of equity capital used in computing the allowable return is the average investment of the owners during a reporting period. Under current law (P.L. 98-21) the rate of return on the average amount of equity is equal to the average rate of interest paid by the Federal Treasury on the assets of Medicare Hospital Insurance Trust Fund during the same period. Prior to May 1983, the rate of return was one and one-half times the interest rate paid on trust fund assets:

Interest Rates on Medicare Hospital Insurance Trust Fund Assets and Rate of Return on Equity Capital

For the Month of:	Interest rate HI Trust Fund* (percent)	Payment Factor	Rate of Return on Equity Capital* (percent)
July 1982	13.875	x 1.5	20.812
October 1982	11.625	x 1.5	17.438
January 1983	10.500	x 1.5	15.750
April 1983	10.625	x 1.5	15.938
July 1983	10.875	x 1.0	10.875
October 1983	11.375	x 1.0	11.375
January 1984	11.500	x 1.0	11.500
April 1984	12.375	x 1.0	12.375
July 1984	13.750	x 1.0	13.750
October 1984	12.375	x 1.0	12.375
January 1985	11.500	x 1.0	11.500
April 1985	11.625	x 1.0	11.625
July 1985	10.250	x 1.0	10.250

* Annualized rate

The amount of the allowable return on equity (ROE) is computed as the product of the average amount of equity capital and the average rate of return during the reporting period. If the average equity during the period was $10 million, and the average rate of return was 12 percent, the allowable return would be $10 million x .12 or $1.2 million. Medicare's payment to the hospital is determined by the share of the hospital's total costs that is attributable to Medicare. Thus, if Medicare inpatient costs accounted for 40 percent of the hospital's total allowable costs, then Medicare's payment for return on equity related to inpatient services in this example would be $1.2 million times .4 or $480,000.

C. Future Payment of Hospital Capital-Related Costs

Public Law 98-21, the Social Security Amendments of 1983, directs the Secretary of Health and Human Services to study and report to Congress on methods and proposals under which capital-related costs, including a return on equity, may be included in the prospective payment system. This report, which was due in October 1984, has not been submitted.

P.L. 98-21 also provides that, if legislation regarding inclusion of capital-related costs under the prospective payment system is not enacted by Congress prior to October 1, 1986, Medicare payment cannot be made for capital costs unless a State has a capital expenditure review agreement with the Secretary of HHS (under Sec. 1122 of the Social Security Act) and the State has recommended approval of the expenditure. The conference report on P.L. 98-21 also expresses the intent of Congress that, if the Secretary has implemented a system of prospective payments for capital-related costs (without any further action by Congress) and the mandatory Section 1122 approval process goes into effect, the Secretary must make adjustments to the payment rates to reflect capital-related costs not approved under Section 1122.

P.L. 98-21 also includes a provision expressing the intent of Congress that, when including capital-related costs under the prospective payment system, new capital projects for which expenditures are made on or after October 1, 1983 may be reimbursed differently from projects begun before that date. In other words, no assurances are given that obligations incurred after that date will be reimbursable on a reasonable cost basis.

Uncertainty about future payment policy regarding capital-related costs is cause for concern on the part of hospitals that have recently begun or completed large capital projects, hospitals that anticipate undertaking such projects in the near future, and the financial institutions involved in financing hospital capital projects. The reasons for this concern and the major issues related to the development of a new policy regarding payments for capital-related costs are explored in the next section.

III. ISSUES IN DESIGNING A NEW CAPITAL PAYMENT POLICY

In adopting a prospective payment system for hospitals under Medicare, Congress sought to establish effective financial incentives (including both rewards and penalties) to control spending in the provision of inpatient services to beneficiaries. Although Congress excluded capital-related costs from the prospective payment system, the provisions of Public Law 98-21 cited above clearly indicate the Congressional desire to include such costs as soon as feasible methods could be found.

Medicare capital-related costs, however, represent only a small fraction of hospital costs currently subject to the prospective payment system. For example, during fiscal year 1984, estimated Medicare hospital inpatient operating costs amounted to about $36.0 billion. Estimated Medicare hospital capital-related costs in the same year amounted to only about $2.9 billion: $1.6 billion (55 percent) for depreciation of fixed assets, $0.4 billion (14 percent) for depreciation of moveable assets $0.7 billion (24 percent) for interest costs and $0.2 billion (7 percent) for return on equity. 13/ Thus, reimbursable capital-related costs represent only about 8.1 percent of total Medicare hospital spending (operating costs) already subject to prospective payment.

Nevertheless, potential alternative capital payment policies under prospective payment have become a topic of considerable discussion and debate, despite

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13/ Rental expenses and other minor elements of capital-related costs are not separately identifiable in the cost reports submitted annually by hospitals to the Medicare program. These amounts are generally included with the reported depreciation expense figures.

the relatively small percentage of funds actually expended by Medicare for such purposes. The purpose of this section is to describe the main reasons for this interest and the issues related to the design of a new payment policy for hospital capital costs under Medicare.

A. Reasons for Interest in Medicare Capital Payment Policy

The Congress, the Reagan administration, various groups within the hospital industry and others have expressed strong interest in the development of new capital payment policies under Medicare. The reasons for this interest are many and varied. First, a number of analysts have expressed concern about the impact that current policy (cost reimbursement) may have on the financial incentives faced by hospital managers in economic decisionmaking. These analysts have argued that cost reimbursement for capital costs coupled with prospective payment for operating costs may create a variety of potentially undesirable incentives including:

--The incentive to substitute capital assets for other resources such as labor. For example, if the purchase of a new information processing system would reduce the hospital's need for clerical staff and thereby lower its operating costs, the hospital would have a strong incentive to make the purchase, even if its total costs (operating costs plus capital costs) would be increased as a result.

--The incentive to finance capital purchases by borrowing. This incentive arises for three reasons. First, Medicare's share of the hospital's incurred interest expense is fully reimbursed. Second, in an inflationary period, depreciation based on historical cost generally does not allow the hospital to recover the full replacement cost of its assets. By the time an asset is fully depreciated (the historical cost is recovered), the price of a replacement asset has generally increased substantially. Thus, the hospital's real (inflation adjusted) equity capital is diminished since it recovers less in depreciation payments than would be needed to maintain the same real value of assets over time. Also, the cost of equity capital is not reimbursed (except in the case of proprietary hospitals).

In addition, these analysts have noted that cost reimbursement permits hospital managers to ignore prevailing market conditions in deciding on the timing of their investment projects. Thus, the hospital administrator whose interest expenses are reimbursed on a cost basis may not need to postpone a major capital expenditure even though interest rates are unusually high. Some analysts have also noted that, under current policy, the Medicare program implicitly subsidizes the capital costs of underutilized hospitals. This occurs because Medicare pays a share of the hospital's total capital costs that is based on the share of total resources consumed by program beneficiaries. Thus, if Medicare's share of hospital resources is 40 percent, the program pays 40 percent of the hospital's total allowable capital costs regardless of whether the hospital operates at 20 percent or 95 percent of its capacity.

Many observers expect these features of current capital payment policy to lead to higher capital costs and higher overall costs for inpatient services than would otherwise occur. It is also important to note, however, that the Medicare program is not the only purchaser of hospital inpatient services. Thus, the strength of these effects may be diminished to the extent that the payment policies of other major payors create off-setting or conflicting incentives.

A second reason for interest in capital payment policy derives from concern about the potential effects of alternative policy options on hospitals' access to capital financing in the future. Many observers have expressed concern that hospitals facing increased competition in the marketplace may experience greater difficulty in obtaining the financing they need if Medicare capital policy becomes more restrictive. These observers argue that a restrictive capital policy under Medicare could lead to deterioration in the quality of services provided not only to Medicare patients but to all patients. These concerns have been expressed especially with regard to rural hospitals and large urban public hospitals which traditionally have had difficulty in obtaining access to capital financing.

Another reason for concern is related to variations in the relative importance of capital costs across hospitals. Although estimated total reimbursable capital-related costs represent on average only about 7.5 percent of total (rather than operating) hospital costs under Medicare, many hospitals have a much greater than average proportion of capital-related costs in some years, while others have a lower than average proportion of capital-related costs. Capital costs, in other words, are unevenly distributed among the hospitals participating in the Medicare program. This is largely due to the fact that major capital expenditures--especially for replacing, modernizing, or adding new buildings and fixed equipment--occur infrequently. Hospitals that have just begun or completed large capital projects may, in any one year, have capital costs amounting to well over 20 percent of their total expenses. Older facilities, on the other hand, can have capital costs amounting to 4 percent or less of their current total expenses. This variation is well illustrated by the distribution of Medicare capital costs to total Medicare hospital costs across hospitals in 1981: 14/

14/ Gerard Anderson, from a presentation to the Advisory Committee on Social Security; reprinted in "Including Capital in Prospective Payment: Questions and Information Pertinent Thereto," Catholic Hospital Association, October 1983. Data exclude return on equity amounts.

Medicare Capital Costs, As a Percentage of
Total Medicare Hospital Costs, 1981

Capital costs/Total costs	Percentage of Hospitals
Less than 4%	25.3%
4% to 6.6%	34.6
6.6% to 10%	22.2
10% to %15	12.6
15% to 20%	3.5
More than 20%	1.9
Mean percentage (all hospitals)	6.6%

As these data suggest, the short-term impact of alternative capital policies under prospective payment may be very different for hospitals in different circumstances.

These concerns raise important issues for the design of a new capital payment policy under Medicare. These issues are discussed briefly in the next section.

B. Major Issues in Capital Payment Policy Design

In general, there are four major issues related to the design and impact of a new Medicare capital payment policy. They are: (1) the basis of payments for capital-related costs, (2) the level of payments for such costs, (3) the nature and duration of a transition policy to ease the change from the old to the new payment method, and (4) the nature of any adjustments and exceptions provided to allow for factors that may affect capital costs but are beyond the hospital's control. These issues are discussed below:

1. The Basis of Capital-Related Payments. Payments for capital-related costs could be based on each hospital's actual incurred costs (continuing current policy), or they could be set on a prospective basis, for example, to reflect the average experience of hospitals in a peer group (e.g., national,

regional or urban and rural averages). The key issue here is whether and to what extent the payments received by a hospital can be influenced by changes in the hospital's behavior. If payments are based on incurred costs, then the hospital's payments are determined by its decisions regarding which capital investment projects to undertake and how to finance them. On the other hand, if capital payments were based on a prospectively determined rate (e.g., a fixed amount per discharge set in advance), then payments would be largely outside the hospital's control. In this case, the payments received by the hospital would be determined by the payment rate and the volume of Medicare discharges regardless of any capital investment decisions it made.

Payment of capital costs on a prospective basis generally would reverse many of the financial incentives faced by hospitals under current policy. Prospective payment per discharge for capital costs coupled with the current system of prospective payment for operating costs would eliminate the financial incentive to favor capital assets relative to other resources. Instead, hospital managers would have incentives to minimize the total cost of delivering services to Medicare beneficiaries. The financial incentives also would be neutral regarding the method of financing needed capital investments. Hospitals would have an incentive to adopt the combination of financing methods (e.g., debt versus equity, short term versus long term debt instruments, etc.), that minimized the costs of obtaining the required capital. Payment for capital costs on the basis of a prospective rate per discharge also would eliminate the possibility that the Medicare program could subsidize the capital costs of a hospital operating at only a small fraction of its capacity. This possibility would be eliminated because payments for capital would be tied to the volume of Medicare discharges rather than to Medicare's share of total hospital utilization.

It should be noted here that these advantages would exist regardless of whether the prospective rate per discharge for capital costs was held separate from, or combined with the existing prospective payments rates for operating costs. These advantages derive from the fact that the hospital under full prospective payment cannot change its capital payment or its total payment per discharge (capital plus operating) by changing its investment decisions. Instead, in order to increase profits (or reduce potential losses), the hospital manager can only reduce the actual total cost per discharge incurred in providing services to patients.

Prospective rates as a basis for capital payments, however, also have some disadvantages. First, payment on this basis would penalize hospitals which have recently completed or are about to begin large investment projects. For example, a prospective capital payment rate per discharge, set to cover the average capital cost per discharge in all hospitals, generally would fall far short of the actual cost per discharge experienced by a hospital that has recently replaced its buildings and fixed equipment. Similarly, an average rate would not be adequate to cover the capital costs anticipated by a hospital that is about to begin a major project. It is likely that such a hospital would have to postpone a major project until surplus revenues could be accumulated to cover the high initial capital costs.

Second, prospective payment for capital costs in conjunction with prospective payment for operating costs may increase the strength of some generally undesirable incentives such as the incentive to increase admissions of relatively healthy Medicare patients while avoiding admission of severely ill patients or the incentive to describe cases as though they belong to a higher paid DRG (DRG-creep). It should be noted, however, that the proportion of the hospital's costs subject to prospective payment would not increase very much as a result of including capital costs. Thus, the potential change in the strength of these incentives might not be very substantial either.

Of course, capital costs need not be paid entirely on one basis or the other. Some analysts have suggested, for example, that the capital costs attibutable to buildings and fixed equipment could continue to be paid on an incurred cost basis while the costs of moveable equipment could be paid according to a prospective rate. The main rationale for this approach is that buildings and fixed equipment represent very expensive and relatively long-lived assets which tend to be replaced only at long intervals. Thus, these assets may have a very pronounced investment cycle of high initial capital costs followed by long periods of declining costs. Moveable assets, which tend to be less expensive and relatively short-lived, may be replaced much more often with the result that the associated capital costs may fluctuate much less from year to year.

Such a mixed system would result in mixed financial incentives too. Thus, for example, hospitals would have an incentive to minimize the costs of all resources except fixed assets. To the extent that buildings or fixed equipment could be substituted for other resources, the hospital would have an incentive to do so even though total costs were increased. For example, renovation of the hospital's main building to make more efficient use of existing space and reduce internal traffic flow could reduce operating costs but increase total costs.

2. The Level of Payment. If capital costs are paid on a prospective basis, then the question of how to set the level of capital-related payments would need to be examined. The level of the payment rates will generally depend on three factors: (1) which elements of capital costs are included in the capital cost base used to calculate the rates, (2) the nature of the update

factors used to adjust the base amount for inflation between the base period and the year in which payment is to be made, and (3) the nature of any adjustments to the base amount.

These issues could be resolved in many different ways. For example, various proposals have suggested that only capital costs historically recognized by the Medicare program should be included in calculating the base capital cost amount. Others have suggested that the return on equity capital paid to for-profit hospitals should be excluded from the base. Still others have argued that the base should include not only historical payments for return on equity for proprietary hospitals, but a return on equity for non-profit and publicly owned hospitals as well.

Issues regarding the nature of the update factors used to adjust the base year amount to the year of payment have a similar range of possibilities. For example, update factors could be based only on proxy measures of changes in the cost of capital, or they could incorporate trends in capital expenditures and in the volume of hospital discharges between the base year and the payment year. Thus, recent increases in the volume of capital expenditures have tended to increase the level of capital costs per discharge and recent declines in the volume of discharges also have tended to increase the level of costs per discharge as the same costs are spread over fewer discharges.

A number of other adjustments to the base amount also could be made. Some analysts, for example, have suggested adjustments to the base amounts for low occupancy hospitals to remove the historical capital cost subsidies paid under cost reimbursement. Other analysts have argued that the aggregate level of capital payments should be adjusted (after updating for inflation) to be budget neutral to the amount that would have been paid if current policy had continued. As noted above, however, different proposals have suggested both higher and lower amounts.

3. Transition Policy. The nature and duration of any transition mechanism is an important issue that has received much attention. Generally, proposed transition mechanisms are designed to avoid or reduce the penalties that would otherwise be imposed on hospitals that have recently completed major capital projects. Most such mechanisms combine a hospital-specific payment rate which reflects the current capital costs of the hospital with a national average or other target rate which reflects the capital payment rate that will apply after the transition period has ended. These rates are initially combined so that the blended rate is mostly based on the hospital-specific component. As the transition period proceeds, however, the blended rate shifts toward the target rate and ultimately, the blended rate becomes equal to the target rate.

Transition periods ranging from 5 years up to as much as 18-20 years have been suggested. Naturally, the longer the period, the lower the potential penalties would be for hospitals that currently have high capital costs. However, hospitals in need of major renovation or replacement in the near future would tend to be penalized instead. This would occur because these hospitals tend to have below average capital costs. Thus, their blended rate in the early years of the transition would tend to be below average. For these hospitals, the longer the transition period, the longer they have to wait until their capital payment rates would approach the average payment rate.

One potential solution to this dilemma may be to periodically recalculate the hospital-specific portion of the blended payment rate based on the hospital's actual costs (e.g., every other year). Under this approach, a hospital needing to make a major investment very early in the transition period could do so without being badly penalized (although the penalty would not be eliminated). The disadvantage to this approach for some observers is that it would require continued use of cost reports and other administratively burdensome methods in order to allow for periodic recalculation of each hospital's actual capital costs.

4. Adjustments and Exceptions Policy. The final major issue relates to choices regarding a number of potential adjustments which could be incorporated in the calculation of prospective capital payment rates. Most of these adjustments would modify the payment rates to some extent to allow for differences in individual hospital circumstances. Some analysts, for example, have suggested that capital costs may vary substantially across DRG categories. These analysts contend that if such differences are ignored, then the payment system as a whole will encourage hospitals to avoid some types of cases (those with above-average capital costs), while trying to attract patients in other categories (those with below-average capital costs). Other analysts, however, have noted that while variations in capital costs across DRG categories may exist, they have not been well documented. Moreover, the traditional accounting methods used to allocate capital costs assign those costs to hospital service departments rather than to the individual services typically used in each DRG. Thus, the available historical data are probably much too crude to reveal differences in capital costs among DRGs even when they are quite substantial.

A second type of rate adjustment considered in some proposals would adjust the payment rates to reflect variations in capital costs across regions or local market areas. Construction costs, for example, almost certainly vary from one market area to another in response to variations in local wage scales, transportation costs for key materials, and other factors. The data available for measuring such variations, particularly at the local market level, however, are quite limited.

Other potential adjustments raise difficult policy issues. For example, should Medicare capital payments be adjusted for certain segments of the hospital industry which have difficulty in raising capital? Some analysts have noted that a major portion of the hospital industry including small rural hospitals and financially troubled urban hospitals has traditionally had great difficulty in obtaining access to debt capital. When they are able to obtain financing, these hospitals generally incur above average costs for capital because of the risk premium demanded by lenders. As a result, a prospective payment for capital costs based on the average cost of capital may not be adequate for hospitals in these circumstances.

Some of these issues could be addressed by allowing exceptions or individual payment adjustments for extraordinary circumstances instead of relying on automatic payment adjustments. Although exceptions policies may be difficult or costly to administer, some analysts believe such policies may have important benefits where the effects of local conditions and special circumstances cannot be systematically incorporated in the payment system.

Several bills incorporating specific proposals to include payments for capital-related costs in the prospective payment system have been introduced during the 99th Congress. These proposals are described in the next section.

IV. LEGISLATIVE PROPOSALS INTRODUCED IN THE 99TH CONGRESS

Several bills which contain provisions to include payments for capital-related costs in the Medicare prospective payment system have been introduced in the Senate and the House during the 99th Congress. A bill entitled "Medicare Capital Payment Reform Act of 1985" was introduced by Senators Durenberger and Quayle on July 16, 1985 as S. 1559. Another proposal entitled "Medicare Solvency and Health Care Financing Reform Act of 1985" was introduced in the Senate by Senator Kennedy et al., on June 24, 1985 as S. 1346 and in the House by Representative Gephardt et al., on March 28, 1985 as H.R. 1801. The provisions of these bills regarding payments for hospital capital-related costs under Medicare are briefly summarized below.

A. The Medicare Capital Payment Reform Act of 1985, S. 1559

This bill would amend Section 1886 of the Social Security Act to incorporate payment of capital-related costs into the Medicare hospital prospective payment system. Capital-related payments would be determined by a flat percentage increase in the hospital's applicable national payment rate for Medicare discharges in each of the Diagnosis Related Groups (DRGs). Capital-related costs of hospitals excluded from the prospective payment system would continue to be reimbursed on the basis of incurred costs. In addition, the bill provides for repeal of Section 1122 of the Social Security Act.

Effective for hospital discharges occurring on or after October 1, 1986, the additional capital-related payment per discharge would be determined by multiplying the hospital's applicable national DRG payment rate for the discharge by its blended add-on ratio. The add-on ratio represents the proportion of operating costs historically accounted for by capital-related payments. Thus, in effect, the hospital's prospective payment rates for operating costs would be increased by an amount sufficient to cover both operating costs and capital-related payments.

The hospital's blended add-on ratio would combine two ratios: (1) the hospital's ratio of payments under Medicare for capital-related costs to operating costs in a base period; and (2) the national average ratio of payments for capital-related costs to operating costs in the same period. The national average ratio, however, would exclude payments to proprietary hospitals for return on equity capital during the base period.

The blend factors used to combine the hospital-specific ratio with the national average ratio would change over 5 years from .95 and .05, respectively, in the first year, to .25 and .75, respectively, in the fifth year. In the sixth year and thereafter, the add-on ratio would be based 100 percent on the national average ratio of payments for capital-related costs to operating costs. Thus, the add-on ratio would shift over a 5-year transition period from a primarily hospital-specific ratio to a national average ratio that would be the same for all hospitals and all DRGs. The exclusion of payments to proprietary hospitals for return on equity from the national average add-on ratio implies that payments for return on equity would be gradually reduced over the 5-year transition period, and completely eliminated by the sixth year. Capital-related payments to a new hospital would be based on the national average add-on ratio alone (i.e., without a hospital-specific component), even during the transition period.

These add-on ratios would be calculated on the basis of hospital-specific data on capital-related payments and operating costs for cost reporting periods ending in the 3 years from fiscal year 1984 to fiscal year 1986. The Secretary of HHS would be permitted to use estimates of costs and payments, if necessary. However, the Secretary would be required to adjust the estimated ratios and capital-related payments to hospitals as additional data become available. In addition, the Secretary would be required to reevaluate the appropriateness of the add-on amounts calculated by these methods, and report to the Congress regarding this issue whenever periodic adjustments to the DRG classification system and weighting factors are made (currently required at least every 4 years).

B. The Medicare Solvency and Health Care Financing Reform Act of 1985, S. 1346/H.R. 1801

This bill would amend the Public Health Service Act and the Social Security Act. Effective January 1, 1986, the bill provides for a transitional Federal hospital prospective payment system based on Diagnosis Related Groups (DRGs) for all private payers (excluding Medicare and Medicaid). States are encouraged to develop their own cost containment plans that meet the Federal requirements outlined in the bill. Hospitals in States with plans approved by the Secretary of HHS would be exempt from the national plan. States that do not have an approved cost containment plan in effect after 2 years would be subject to a stricter national hospital rate-setting plan affecting all payers for hospital services. The bill also contains provisions amending the current prospective payment system under Medicare to include capital and physician costs.

The capital-related provisions of this bill would amend section 1886 of the Social Security Act to establish prospective payment rates for making payments to hospitals for capital-related costs under Medicare's prospective payment system. Hospitals excluded from the prospective payment system would continue to be reimbursed for capital-related costs on an incurred cost basis. In addition, these provisions would prohibit payments to hospitals for a return on equity capital.

Hospitals included in the Medicare prospective payment system would be paid a DRG-specific, regionally adjusted, prospective amount per discharge for capital-related costs in addition to any DRG payments for operating costs. The capital-related payment amount for a discharge in any DRG would be determined by multiplying an updated capital-related base amount by the capital-related DRG relative weight for the DRG. The updated base amount would be calculated as the average capital-related payment per discharge in the base period (FY 1980 - FY 1984), updated for inflation for each year between FY 1984 and the year in which payments were to be made. The capital-related DRG relative weight for the DRG would be calculated as an index number (e.g., 1.439) which would indicate the relative usage per discharge of capital-related resources in the DRG compared to all other DRGs. The Secretary of HHS would be required to establish a weighting factor for each DRG, taking into account data on State experience with capital-related reimbursement systems. In addition, the Secretary would be required to adjust the capital-related DRG weights at least once every 4 years, taking into account factors which may affect the relative use of capital resources across DRG categories.

The payment amounts based on these factors (the updated amount x the DRG weight) would be adjusted for regional differences in the level of construction costs. This adjustment would be applied to the fraction (determined by the Secretary) of the capital-related base amount that is attributable to construction-related costs.

The Secretary also would be required to make adjustments in the payment rates, for individual hospitals, in certain circumstances. Payment rates for admissions in excess of the hospital's base year admission volume would be paid at 40 percent of the normal rate (50 percent for hospitals in States with an approved State plan). Second, if a hospital could demonstrate that its capital-related payments under this payment method were significantly less than the amount needed to meet principal, interest and lease payments for a project obligated before January 1, 1986, then the Secretary would be required to make additional capital-related payments to the hospital. However, total capital-related payments to the hospital including such additional payments could not exceed the total financial requirements of the project.

Senator DURENBERGER. The hearing will come to order. Two years ago, the Congress established the prospective payment system, or PPS, to replace the cost-based reimbursement method used by Medicare for paying for in patient hospital services for Medicare beneficiaries. Under the cost-based payment method, hospitals were encouraged to maximize their costs, what we called the "more is better" syndrome, in order to maximize their reimbursements and, therefore, their profit. PPS, on the other hand, encourages hospitals to provide only those services that are actually needed. Payment is based on a unit price for an episode of illness. The Congress initially limited PPS to hospital operating expenses. Depreciation, interest, and other capital-related items cannot currently be reimbursed under PPS and, therefore, continue to be a pass-through cost. The Congress intended to include these capital expenses in the Medicare prospective payments, but was not prepared to make this change when PPS was enacted in 1983. Instead, the Congress set a deadline for itself of October 1, 1986, to implement a new policy. It also instructed the Secretary of Health and Human Services to prepare recommendations on the most appropriate method of incorporating capital expenses in the PPS costs. A report of these recommendations would be presented to the Congress by October 1, 1984. It is now November 8, 1985, and we are still waiting for the report. Last summer, I began to grow concerned that this report was late. I don't know why it took me until last summer to catch on to the fact that it was 9 months late. [Laughter.]

And no progress was being made in Congress to develop a new payment policy. I was particularly frustrated because I think I am the one who talked Senator Gephardt out of a much shorter way of implementing this, and I am the guy that sort of begged off until October 1, 1986. So, I feel some responsibility when my administration can't deliver on a promise that was very carefully crafted with their cooperation back in the cloakroom of the Ways and Means Committee on one of those late hours in March 1983. I was particularly frustrated also because the October 1, 1986, deadline requires congressional action well in advance of October 1.

So, to get the discussion moving, I developed with my colleague from Indiana, Senator Dan Quayle, S. 1559, which is entitled "The Medicare Capital Payments Reform Act." This proposal is by no means perfect policy. Nothing that I ever do is, although it has effectively served its purpose by focusing the attention of the subcommittee, the administration, and the hospital community on the issue of capital reimbursement. This hearing this morning was originally intended to serve as the next stage in the process of developing a new Medicare capital payment policy. We scheduled it several months ago to allow HHS sufficient time to complete its recommendations and to issue a report. Unfortunately, the report will not be delivered today, nor is it clear that any formal recommendations will be forthcoming from Dr. Helms on behalf of HHS this morning. Therefore, we will view today's hearing in a positive way as an opportunity to review the progress that the Department has made to date on the issue and to receive whatever guidance we can on the key technical questions involved with establishing a new payment policy.

Following this hearing, I intend to redraft S. 1559 incorporating what we learn today and the recommendations made by a wide variety of outside experts who have also been working on this issue. The subcommittee will then have a hearing on the new bill in February or early March 1986 so that it can be further refined for inclusion in the Finance Committe's fiscal year 1987 reconciliation bill, where I assume we will do all of our authorizing legislation. I cannot overemphasize the importance of the Medicare reform process or congressional action on capital payment policy. If Congress does not act by October 1, 1986, then 1122 facility review for Medicare becomes mandatory. That would be a mistake. This type of regulation is a bankrupt exercise. A regulation like 1122 review and certificate of need as it has been practiced has not proven to be an effective cost-containment tool. Moreover, it is a clear impediment to the development of a competitive health care marketplace.

An even more compelling reason for action is the fact that the Social Security Amendments of 1983 give the Secretary of HHS the prerogative to alter Medicare payment policy for hospital capital, whether or not the Congress acts. This means that the same Office of Management and Budget, which for the past 2 years has been directing the current Secretary to use the hospital PPS rate updates to meet their arbitrary budget cutting goals, will also have an opportunity with the new Secretary to use the new Medicare capital payment policy to make further cuts. The purpose of restructuring the Medicare capital payment policy is to make it consistent with the objectives of PPS. Arbitrary cuts in payments for hospital capital expenses, regardless of the rationalization for the cuts, will work to undermine Medicare and health care reform.

Real budget savings and deficit reductions will come from Medicare reform, but if immediate savings goals overshadow proper management of the reform process, we are all going to lose more than the goodwill and the cooperation of America's hospitals and doctors. These actions will threaten the quality of hospital services available to Medicare beneficiaries as well as their access to these services, and special burdens will fall on inner-city hospitals, on rural hospitals, and on hospitals in areas of expanding elderly populations. Despite the current budget pressures, the Congress must realize that the hospitals and the doctors of this country are involved in an unprecedented process of health care reform. The eyes of the world are turned to this reform process in the United States, and that process will mean both more cost effectiveness and a higher quality of health care to the people of this country in the future. Medicare needs to promote rather than to stifle that process.

As I introduce our witness today, Bob Helms, since that introductory statement was not necessarily complimentary of the administration which employs him, let me, on the other hand compliment Bob and his assistant, Kathy, in particular, and others who have done a marvelous job. Maybe I could think of a better superlative, but I think the people who have done the work on capital payment are absolutely terrific. We have worked together, both at my level and at the staff level, for 2 years and I think that you, Bob, and your staff have approached this in a very thoughtful way, and while it may not be reflected in a product that has the political stamp of approval on it, I think no one can argue that you have not done a thorough job of analyzing a lot of the factors, and lot of the policy, and some of the fiscal pressures that are in the system. So, I look forward this morning, and I think a lot of other people, do too, to your taking us through the presentation on the background; and I may ask you some questions that get at some of your personal thoughts on some of these issues, if you don't mind that. And I will hold you harmless from whatever Doc Bowen may be told to do to you after the fact; and we did discuss this a little bit yesterday, and so there should be no concern in that regard. I told him we have to stop calling him "Doc Bowen" and we won't call him "Ms. Secretary" either, but I really feel very good about the next 3 years. And I think that the kind of perspective that he will bring to this process is very unique and will be very interesting for us as you look back over previous Secretaries of this Department. He is different; he is his own person; and yet, I think he understands enough about political realities to do as good a job within that perspective as Margaret Heckler also did in my opinion.

So, I come here this morning with that announcement in our pocket from the President, and I thank the President for complimenting a lot of us who have known Governor Bowen over the years, by the President placing his own confidence in him; and I look forward to great things coming out of this process and some of the others that you are involved in. So, why don't we proceed? I know you have a written statement, which has been slightly altered since the first one I read; but whatever it is right now, it will be made part of the record, and you may proceed to add to it or summarize it.

STATEMENT OF ROBERT B. HELMS, PH.D., ACTING ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC, ACCOMPANIED BY KATHLEEN MEANS, STAFF ASSISTANT

Dr. HELMS. Thank you, Mr. Chairman. I did want to introduce Kathleen Means, who has had a major part in coordinating the analysis and the writing of the report. Unfortunately, I cannot blame her for the delay; I will have to take responsibility for that. I do thank you for your comments. I look forward to working with the new Secretary. I do think we have the analytical ability to present to him some good options for this. Since you and other people have copies of the testimony, I think what I would like to do is just hit some high points of that, until it gets over to the options; and then I will read the latter part of the testimony. Your opening statement has already reviewed the legislative history—what Congress intended for us to do with this study. The responsibility within the Department was given to ASPE, Planning and Evaluation. We have worked closely with HCFA. Page 3 of the testimony lists a number of organizations from which we have sought input, both analytical about data and their options and their analysis of options. It also lists a number of studies which the Secretary has sent to the Department. These form a major part of the background information for the report. I will reiterate that our analysis is for in-patient hospital costs only. It does not consider what to do with the outpatient capital payments care or skilled nursing facilities. That I think, will have to come later.

A few words about what has affected capital investment in the hospital industry in this country in the post-war period. Between 1946 and 1981, annual medical facility construction increased by some 365 percent, from an annual amount of about $200 million in 1946 to now what is estimated to be about $7.5 billion in 1981. This has been influenced by several factors. First is the Hill-Burton legislation, which was passed in 1946, which was the major source of capital funds for voluntary and public hospitals. Also, the growth of private health insurance, which brought with it a recognition of capital as a legitimate operating expense by third-party payors; and this enabled many hospitals to fund depreciation and interest and build internal reserves. It added stability to the hospital market, and it reduced the risk of hospital investment. The two-party loan guaranteed program under the Federal Housing Act improved access to debt financing. By the end of 1984, 226 mortgages that had been insured had a total value of $4.2 billion. Another major influence is the tax-exempt revenue bonds.

Senator DURENBERGER. Bob, as long as this is going to be kind of informal this morning, can you go back and elaborate for me just a little bit on the section 242, the issue that you have just left. Do you have a personal familiarity with that, so you can explain where that one has fit? I take it you were talking about the FHA Loan Program?

Dr. HELMS. Right.

Senator DURENBERGER. Can you explain where that has fit in this whole business about capital? I noticed that we are still making some of those, aren't we? Didn't we just recently make a couple of them?

Dr. **HELMS**. Not new ones. I would like to let Kathy comment on that, since I am not an expert on that.

Ms. **MEANS**. I am not entirely an expert on the loan and mortgage insurance guarantees either. However, we feel that the major purpose that is served is to allow certain hospitals to obtain capital investment financing that they otherwise would have had some considerable difficulty in obtaining. The primary issue is that there is not much of a secondary market for hospital assets; and so mortgage loan and insurance guarantees help hospitals to obtain financing.

Senator **DURENBERGER**. Do you know if we are still making those loans?

Dr. **HELMS**. Chip says yes. Direct loans are no longer being made, but we continue to insure mortgages. [Laughter.]

Senator **DURENBERGER**. Maybe we can explore that. Since this is more or less a background record, that is one that I would like to see us add an additional dimension to. My impression is that, if you get enough political influence in New York City or some place like that, you can get one of these loans; and I don't know what it really has to do with what was the original purpose, which was that if you don't have access some other place, you can go here to get it. All right. I am sorry. Go ahead.

Dr. **HELMS**. We will try to get you more information on 242. Tax-exempt revenue bonds. Between 1971 and 1977, tax-exempt financing increased at an average annual rate of 52 percent, adjusted for inflation. Twenty-six States currently have authorities or agencies which can issue tax-exempt revenue bonds for nonprofit health care facilities. For the nonprofit hospital sector, in 1968, 40 percent of the investment was financed by debt, and the majority of this was subject to tax. In 1983, 60 percent was financed by debt; and of this amount, 80 percent was tax exempt. This has cost the Treasury $2.4 billion; that is the estimated tax loss for fiscal year 1986.

Senator **DURENBERGER**. Could I ask you at that point whether HHS is making any specific recommendations with regard to—and you don't have to detail them—but would you be willing to make some recommendations about the utilization of tax-exempt bonds, as we go through the whole business of revising income tax policy?

Dr. **HELMS**. We would certainly be glad to provide you with information. To my knowledge, we have not been asked. We don't dwell on it a great deal in the draft report.

Senator **DURENBERGER**. Have you in any other place? Have you been asked to make recommendations on the future tax policy as it relates to hospital financing, capital financing?

Dr. **HELMS**. No; not that I am aware of, but I would have to check it out. It is entirely possible that the Health Care Financing Administration may have been asked to do something on that. The other factor that has affected this, as you had mentioned, is the certificate of need regulation established by the Health Planning Act of 1974. Of course, this is market entry regulation. We think it is, as you said, not effective and anticompetitive. One other aspect, I think, of planning. I personally would like to see us get out of this; and I think incorporating capital into prospective payment will give us a good chance to do so. But in a sense, the planning process costs Medicare money because, as the hospital industries have said to us, they are very reluctant to decertify beds when they have spent 10 years in this process of getting them licensed. So, Medicare now pays on a proportion of Medicare days-to-bed capacity, not total days. So, if you have a hospital with an excess capacity, Medicare is paying a partial subsidy for that excess capacity; and to the extent that hospitals would be willing to decertify their beds that they knew they didn't have to go through this certificate of need process, I think it would be more efficient for us in the future.

Senator DURENBERGER. Could I stop you again at that point, and ask you whether you have any recommendations for alternative approaches to a certificate of need? I think we are in agreement—I think I called it a futile exercise, or something like that—but I suppose there are ways in which a certificate of need could be used to get over the problem that you just outlined. That is, if the certificate were granted for a new construction or something, on the basis that the occupancy of that hospital would be about 85 percent or some other figure; and then failing that, you could condition a certificate, could you not?

Dr. HELMS. I suppose you could do that, but I just think that if you incorporate capital into prospective payment, you will have then tied Medicare payments to the Medicare volume. And hospitals already have a different incentive than they had when everything was cost reimbursed, but with operating costs and capital tied to the DRG system, they would have, I think, strong incentives to make their own decisions about that. That is one of the major goals for reforming the system: to put the incentives for efficiency onto the hospital management and not have somebody else decide it. So, I suppose you could do that, but I just think it will be redundant. Then, you have section 1122, which many people lump together with certificate of need, but it is really somewhat different. It has established by the Social Security Amendments of 1972, and it is a reimbursement control.

The Secretary can withhold capital payments for Medicare and Medicaid if a particular hospital project is not approved by a State planning authority. Now, I agree with you that I don't think we want section 1122 to go into effect. Only 16 States and the Virgin Islands currently have 1122: but as you said before, it would be required if Congress does not act. Now, those are not the only factors that have affected the hospital market, but I think it is a list of some of the major ones that have influenced the growth of capital in this country in the post-war period. Now, let me go to a discussion of options; and I will take up on page 12 of the testimony: cost-based payments.

Cost reimbursement from capital contains many of the undesirable elements that cost reimbursement for operating expenses did and that originally prompted the creation of the prospective payment system. These problems relate primarily to undesirable incentives and encourage excessive spending on capital and result in maldistribution of Medicare payments for capital. Under cost reimbursement, the Medicare Program basically reimburses the hospital its actual incurred cost of capital investment, without regard to whether that investment is necessary contributes appropriately to efficiency of operation, or was financed in an optimal manner. Payment amounts to individual hospitals are directly related to a hospital's rate of spending levels for capital investments. If a hospital's spending level of capital increases, so does its Medicare capital-related payments, assuming constant Medicare occupancy. Cost reimbursement does not foster prudent hospital capital investment behavior.

The current split of DRG payments for operating expenses and cost reimbursement for capital creates a positive incentive for hospitals to substitute capital for labor, perhaps inappropriately from an efficiency standpoint. While hospital decisions to invest in capital rather than labor may be appropriate in some instances, the Medicare payment system should be, we think, neutral with respect to such decisions and not foster one category of input over another. And I think this was one of our objectives from the very start in terms of efficiency that we should not be influencing that decision at the margin on the part of the hospital manager, about how they should operate their own hospital, given their local conditions and their local labor prices and the price of capital, and so on. The present cost reimbursement policy could be continued for capital-related expenses in conjunction with health planning programs, such as certificate of need or section 1122. I think I have already covered this part. I think they are ineffective and, as I said, redundant. Let me go on.

Congress specifically asked us to look at section 223 type cost limits which had been, some people thought, done rather successfully for operating costs; but the situation is different with capital. Under a section 223 approach, hospitals could be sorted into peer groups according to variables such as geographic location and bed size and a maximum payment limit on hospital specific capital reimbursement could be set at some percent of the mean capital costs for each group. The capital costs that each hospital uses for calculating the group limit would be defined through reasonable cost principles. This approach would have the effect of limiting capital payments to hospitals with especially high capital costs. If the limits were not too stringent, a range of payment levels would still be available to individual hospitals below the limit, and payments would not be frozen relative to a high or low point in hospital cycles. This concept is very problematic as applied to capital costs.

Capital costs can vary tremendously over time for a particular hospital, depending on its overall average level of investment in capital, and on whether it has recently undertaken a major investment. High capital costs in any given period may simply reflect a recent major investment and bear no relation to whether or not the hospital is operating efficiently. In addition, there are problems associated with determining an appropriate basis unit around which capital's cost should be calculated and reimbursement limits imposed. There are administrative and equity problems related to both prospectively and retrospectively applied cost limits. Any section 223 limit approach involves continuation of the cost reporting system providing a data base from which cost limits can be developed and applied. In other words, you should not expect us to recommend that.

AVERAGE PAYMENT METHOD

Given the basic design of the prospective payment system, any approach that incorporates payment for capital into the system by definition entails averaging. There are two general mechanisms for implementing an average payment method: the uniform percentage add-on and an all-inclusive rate. Each of these approaches would require decisions on the following elements of a payment method: the mechanism by which payment is made; the average payment level; a transitional period to move from hospital specific payments to average payments; the distribution of capital inputs across DRG rates; and a factor for updating prospective amounts that reflects capital as well as operating expenses. One should also consider the relationship of a capital payment policy, as I said before, to CON and 1122 programs.

The next order of decision includes the mechanism, whether you want a percent add-on or an all-inclusive rate, which I will describe more when we get to the charts; the level, of course, involves judgments regarding the appropriateness of currently allowable costs such as return on equity payments for investor-owned hospitals. Then you have to decide on a transition, if in fact you want to ease the people into this, going from one system to another. We have had suggestions all the way from nothing to forever; but most of the suggestions range, I would say, from 3 to 15 years. Blending proportions for the Federal versus hospital-specific portion of the capital rate during the transition would have to be decided, and the source of the cost-reporting base for the hospital specific portion. That is, are you going to fix the base? I think you had suggested in your bill to allow it to change over time under the old cost reporting rule.

Now, incorporating capital into the DRG base payments would break the link that currently relates Medicare revenues for capital to the value of a hospital's current capital assets. That is, high rates of investment in capital generate high capital-related revenues, while a low capital asset base generates low cost-based revenues. The latter is a problem particularly for chronically undercapitalized hospitals such as large urban public hospitals in old and deteriorating physical plants. Cost reimbursement for Medicare or other payors does not generate revenues sufficient to permit such hospitals to improve their capital stock unless supplemented by other revenue sources. The percentage add-on and an all-inclusive rate mechanism share these advantages, and either would be a marked improvement over the current cost based system, with or without controls. However, there is an important difference between the two methods.

The percent add-on method would perpetuate the current practice of distinguishing between medicare capital and medicare operating payments, whereas the all-inclusive rate method would eliminate the distinction by creating an all-inclusive prospective rate that would provide hospitals a total revenue amount for treating medicare beneficiaries. The most important aspect of incorporating capital into DRG based payments would be that medicare payments would be linked to medicare volume and case-mix rather to the hospital's total fixed costs, which may be excessive due to either spending levels or unusued capacity or other historical accidents. Both mechanisms require a transition period to ease the impact of hospitals that are currently highly leveraged with respect to capital investment. The transition would be similar to the one currently used to implement the prospective payment system on the operating cost side.

In the area of capital, hospitals are less able to respond quickly to significant changes in payments for capital due to the sizable, longer term, and relatively fixed aspects of the costs involved. In light of the inefficiencies and disparities inherent in the current cost-reimbursement method of medicare payments for capital-related hospital costs, I believe that a total revenue average payment approach represents a major step forward to a unified, coherent medicare payment policy for the hospital industry. Such an approach could stimulate desirable changes with respect to the future levels and the distribution of capital investment.

We are currently in the process of developing more detailed specifications to implement this recommendation. Our recommendation is designed to incorporate an average amount of capital directly into the DRG payments. Thus, when implemented, all participating PPS hospitals will be paid on an average rather than hospital-specific basis for capital as well as operating costs. This approach complements the incentives for efficiency of the prospective payment system for operating costs. It unifies the rate structure and leaves the payment incentives neutral with respect to operating versus capital decisions made by hospital management. It encourages hospitals to make capital investment decisions which are sensitive to market conditions.

Linking the flow of medicare capital dollars to medicare admissions and case-mix means that the distribution of medicare capital payments becomes self-regulating. That is, those hospitals that compete successfully for medicare patients and those areas of the country where medicare beneficiaries are concentrated and use inpatient hospital services, will automatically receive additional medicare payment for capital as their medicare volume increases. Now, as an example of that, if it is true that the relatively more people who are eligible for medicare are moving to certain areas of the country, then the medicare payments would automatically follow them over the long run. Correspondingly, those hospitals and areas that serve low numbers of medicare patients and that have overall low occupancy levels will experience an appropriate decline in medicare payment when this policy is implemented. Certain classes of hospitals that have invested at levels lower than the national average will, to the extent they retain medicare volume, experience an increase in average medicare payments. Other classes of hospitals may experience a decline in overall average medicare payments for capital.

Since the ultimate goal of this approach is to eliminate the distinction between capital and operating payments, the test for hospitals will become one of evaluating the total cost of serving medicare patients relative to total medicare revenues, with each hospital free to choose the optimal mix of capital and other inputs in providing that care. Given the relative magnitude of medicare revenues to total hospital revenues and the incentives of the prospective payment system for cost-conscious behavior, a highly regulatory health planning apparatus would not be necessary under an approach that incorporates an average payment for capital.

When a refined system is implemented, the financial discipline imposed by the prospective payment system would have considerably more profound and desirable effects than market entry regulation or post-hoc reimbursement penalties. I will conclude at this point. I would like to go to a few charts which we have here, which I think will bring out some of the aspects and our basis for future questions.

Senator **Durenberger**. Maybe you can back it against the wall and then more people can see it. Can you see it?

[Showing of charts.]

Dr. **Helms**. Now, this first chart is something I am sure everybody in this audience is tired of seeing. They have been seeing it for about 2 years.

Senator **Durenberger**. Well, then turn it around——

[Laughter.]

Does anybody back there want to look at the charts? [Laughter.]

Dr. **Helms**. There are several important aspects of this. It just gives the basic information. It is based on the last completed audit data we have for 1981, projected forward to 1984. So, we have a total of medicare payments going out to hospitals of about $39 billion, and only about 7.4 percent of this goes to capital. The other is under the DRG system as part of the transition being phased in. If it doesn't get delayed, that will be, on the operating side, all on the basis of national rates by the start of the next fiscal year. So, it is important to keep in mind that, compared to the old system where operating and capital costs were costbased, the incentives are already changing for the hospital sector. The hospital manager has to look at this in terms of: If he typically gets about 40 percent of his revenue from medicare, he is now getting roughly 93 percent of the capital amount from the DRG operating side. So, capital is a small part of the pie. It gets distributed, that is, about $3 billion per year, with about 55 percent going to depreciation of fixed assets, 14 percent to depreciation of movable assets, and then interests cost of about 23 percent, and then return on equity about $200 million in 1974, or 7 percent of that capital amount.

[Change of chart.]

Dr. **Helms**. Now, there is probably no chart that can simplify the concept of how we compute all of the DRG amounts for hospitals, but here is an attempt. And forget about the transition of operating; I am just talking about the operating side methodology right now. Forget about the transition into the system. Assume that it is fully implemented on the operating side. What HCFA does is compute two standardized amounts: one an average operating cost for the urban hospitals and another one for rural hospitals. It then takes this and breaks it down into labor and nonlabor components for the purpose of applying the area wage adjustment to the labor part only. So, that area wage adjustment gets applied to the labor part, and then it gets put back into the standardized amount. We then distribute this average cost across the DRG's on the basis of the relative intensity of each DRG—those which use more resources than others; and that is done in an index number system which distributes the DRG amount. So, then, that determines what a hospital gets on a payment per discharge for a particular DRG.

Senator **Durenberger**. What you have is an urban labor times the DRG rate and you have a rural labor adjusted times the DRG and then you have an urban nonlabor times the DRG and a rural nonlabor times the DRG.

Dr. **Helms**. That is essentially right, but the labor and nonlabor really gets folded back into the standardized payment amount before it gets multiplied by the DRG rate. All right?

Senator **Durenberger**. Yes.

Dr. **Helms**. Then, for teaching hospitals, there is another adjustment for the indirect teaching allowance, which is based on their residencies per bed and a formula; and that we have not done, but that will also have to be adjusted, once you get capital incorporated into the standardized amount. You would have to readjust that to make it technically correct. So, right now, that indirect teaching allowance is based on the operating cost side only. But let me use this chart to say that what we are recommending when we say that we want to go to an all inclusive rate is that eventually you just go and compute the standardized payments amount for rural and urban, including total cost, and make no distinction between operating and capital costs. That gets you out of a lot of arbitrary decisions about some kinds of pieces of property and so on. We think it is difficult to draw a conceptual line between those, and so there are administrative problems that this gets you out of. That is also the advantage of having a total revenue approach rather than the percent add-on because with the percent add-on you would have to continue to do this for operating costs and keep them separate. When you think about an all-inclusive rate, when you get to it eventually, you would make no distinction between capital and operating costs.

Senator **Bradley**. What would be the effect of an all-inclusive rate that caps capital expenditures?

Dr. **Helms**. Pardon me?

Senator **Bradley**. What would be the effect of lumping labor and nonlabor together and also capping capital expenditures?

Dr. **Helms**. OK. There are several ways that that could possibly be done. You are referring to such as updating it in a limited amount or just freezing it?

Senator **Bradley**. Saying capital expenditures not above *x* percent.

Dr. **Helms**. *X* percent for a specific hospital?

Senator **Bradley**. *X* percent of a hospital's costs essentially. There is talk of putting a cap of 7 to 8 percent of capital expenditures.

Ms. **Means**. Perhaps I can clarify that. The 7-percent number is an estimate of what the average payment level would be if we incorporate capital into the standardized amount relative to total operating payments. However, we would be updating the total prospective payment amount every year by a market basket index that would incorporate capital. So, the capital payment, in effect, would be allowed to increase over time as would the operating payment.

Dr. **Helms**. But I think your question is: What if you limit that?

Senator **Bradley**. The capital costs would increase over time as a part of a market basket?

Dr. **Helms**. The market basket now only has operating factors in it, and one of the technical adjustments we would have to make for this system is to incorporate several capital components into the market basket so that that market basket update, to the extent that people allow it to be the factor that updates the DRG rates, would include capital aspects also. In other words, if for some reason in an index sense if capital components, like the price of concrete, happened to increase, then that would be reflected in the index.

Senator **Bradley**. How would that affect planning, if you were waiting for each year's new rate to come out, as opposed to knowing that you would get a certain amount of capital expenditures every year?

Dr. **Helms**. That is a problem that the hospital industry has with the present system because you have to remember that approximately 93 percent of this is now going into the operating side, and so the hospital manager has to view this in terms of the total revenue he expects from Medicare. The operating side is much more important in terms of their future planning at this point. They now are living with cost-based reimbursement, so they do have the uncertainty about what is going to happen to capital costs, whether it is going to continue on a cost basis. What I am saying is that, with this new system, having the uncertainty about what will happen to the update factor, I think they could expect capital expenditures to go along with the general rate of inflation. I see no particular reason that they wouldn't follow along with that.

Senator **Bradley**. How would it take into account differences between hospitals and between regions of the country?

Dr. **Helms**. I don't think it would.

Senator **Bradley**. It would not?

Dr. **Helms**. I would not recommend it. I know that some people have raised that—that there are construction cost differences and so on—but I think you have to remember that, on the capital side, the construction cost is only a small part of what we are reimbursing for depreciation and interest. And I would argue that the interest market is essentially a national one. I don't think there is a lot of variation in interest costs around the country. There may be some variation in construction costs, and I am sure there would be in different regions; but I think that would be a minor part, and I would not personally recommend that we have any kind of regional variation in that.

Senator **Bradley**. If HCFA wanted to change the way the capital cost portion now works, would you have the authority under current law to do that, or do you need legislative action?

Dr. **Helms**. We need legislation. Well, that is somewhat debatable. Some people have interpreted the language now that the Secretary has the authority to go ahead and include capital and prospective payment, with the mandatory 1122. But if you want to establish a specific proposal, which is like this total revenue thing, I think we do need legislation to do that. You could specify things about the update factor and those things there.

Senator **Bradley**. Thank you.

Dr. HELMS. Should I continue?

Senator DURENBERGER. Go ahead.

[Change of chart.]

Dr. HELMS. I think most of this has been covered, but let me review the advantages we think we get from incorporating capital into prospective payment. As I said before, the payments would be linked to the Medicare volume, not the sort of historical value of the current assets; and that would have the advantages of being basically self-regulating. It would, we think, eliminate the current advantages of investing in capital rather than labor, when people face that marginal decision, and using debt financing rather than equity financing. In other words, all of the historical analysis of what was wrong with the capital payment system brought out that at the margin we influence management to invest in capital, even when it was not inefficient. In other words, we changed the relative price, and also that we greatly encourage them from several of these programs to do this with debt financing. We think it would provide an incentive for the hospital to be prudent and cost effective in its planning for investment in plant and equipment. In other words, they have really got to look at their own individual local market and decide, like every other business—most other businesses in this country that don't have somebody paying their costs—they would have to look at the long-term expectations of their marketplace: what they expect to happen, whether this investment is worthwhile. And let me point out that that doesn't mean that people are going to stop investing.

If somebody has a good market and they have good potential to go out there and compete for patients, investing in capital is a very good way to do it. They have to renovate. They have to get the right equipment. They have to build for capacity and so on. Some people even have to relocate. So, when we say that the system should encourage cost effectiveness, it means that they should look at their own local situation to decide how to do it. They can't just automatically assume that it is best to invest in capital. And as I have said several times this morning, I think it will give us a great opportunity to get away from formal capital health planning programs. Also, since people have brought up this business about idle capacity, we think this new system of incorporating capital into prospective payment would reduce the current incentives to maintain idle capacity. People would have an incentive to make sure that the number of beds is what they think as a manager is appropriate for their market. Any other questions on that?

Senator DURENBERGER. No.

[Change of chart.]

Dr. HELMS. Now, if you are going to have a transition period, there are several decisions that you have got to make, which we have put up here to illustrate. We are working on the analysis of these, and we do not have agreement about all the details on them yet; but as I said, we have suggestions from no transition to forever, but you have to decide how many years you want to use to phase this in. You can also decide—and I even have another chart to illustrate an uneven blending—but that is getting at the proportion which you maintain on the hospital-specific side and how fast you work it into national rates. And then on the hospital-specific payment, you have some basic decisions about whether you want to establish a base for each hospital.

Senator DURENBERGER. What kind of base could I use on my bill?

Dr. HELMS. I think it is a 3-year average, if I remember, for——

Senator DURENBERGER. There would be various ways to go about that baseline, too, wouldn't there?

Dr. HELMS. Yes, but you have a couple of problems. One, the Department has a problem with getting up-to-date audited data, and right now HCFA hopes that by next year we will have 1983 audited data. And in 1986, we would have a sample of 1984 audited reports for 1,200 hospitals, which would be a good sample; and we could use that for setting a base. But the question here is: How do you set a base for each specific hospital? We don't know of any way when you are using audited data, because of this time delay, that you have the major disadvantage that when you set a base, you are going to catch some hospitals that have invested since that audit—you are going to catch them short. In other words, if they have just issued a major bond for a new project, they are going to get caught short for that. In their investment cycle, they are going to be the relatively high capital hospital at that point—you are going to catch them. So, a way out of this is to continue to allow the reasonable capital cost operating rules to apply to an individual hospital throughout the transition period. If you are going to pay them a certain percent on hospital-specific, you pay them a certain percent of what is on their cost report.

Senator BRADLEY. Could you tell me how you are going to handle that if you blend capital into the prospective system?

Dr. HELMS. Could I just show the next chart, because it illustrates that?

Senator BRADLEY. All right.

Dr. HELMS. It shows even an uneven blending, and I am not sure if it addresses your question, but I think that it does.

[Change of chart.]

Dr. HELMS. Now, at first you may say as I did, why did we change the numbers on a 5-year blend? We have had charts which went 80, 60, 40, 20. If you think about it, that got to 100-percent national rate by the fifth year. So, in essence, it was a 4-year transition period. What this is is a true 5-year transition; and if you wanted to have it even, you would reduce it by one-sixth of the amount on the hospital-specific each year. So, you could have it coming down from a little over 83 percent hospital-specific the first year, and getting down by the third year it would be 50/50, and so on. Now, you can contrast that, and that would be a sort of an even or straight line phase-in compared with one which is uneven; and the reason for going to an uneven phase-in is to keep the hospital-specific relatively high in the early years and then drop it off fast. What that does is it eases those hospitals into it.

Senator DURENBERGER. That may be in part what Senator Bradley was trying to get to.

Dr. HELMS. I wanted to explain that now, to relate to your question.

Senator DURENBERGER. On the question of uneven—Go ahead and go over it again.

Dr. **Helms**. OK. The even side, you can make proportional changes, and what this does, if you will look at the hospital-specific on the left side, it takes it over 5 years. By the sixth year, if you drop it one-sixth each time that you are paying hospital-specific, for 5 years each hospital would be getting some proportion of what it was getting on this hospital-specific amount, either based on a hospital-specific base or on the cost reports, whichever way you choose to do it. And in the sixth year, you would then go to a full national rate, the total revenue approach. An uneven phase-in keeps the hospital-specific relatively high—like 95 percent, 80 percent, 60 percent—so that it eases those hospitals into the system more gradually.

Senator **Bradley**. I think that the uneven blend is clearly more generous to high capital-cost hospitals. How do you determine which blend to use? Is it an option? Do they pick whether they want uneven or even?

Dr. **Helms**. Let me point that, while it is better for the high capital hospitals, and I think that is the objective of a transition system—to ease people in from an old system to a new one—it does have the disadvantage that those people below the average would get their increased payments at a slower rate, if you have an uneven transition.

Senator **Bradley**. Yes. What do you say to this idea—since we now use a prospective system for noncapital costs, we should only deal with new capital, and old capital should be dealt with in the present way—the present reimbursement system? The argument there would be that a lot of the capital investment that has been made by hospitals was made with the expectation of the present reimbursement system; and then, suddenly, you say we are no longer going to do that and hospitals have to change systems in 5 years. This would be a serious disruption to their financial planning, and it also perhaps endangers the financial stability of the hospital.

Dr. **Helms**. Let me make several statements about old and new capital. There were some very serious proposals, and we looked at them a great deal; and they were made for the very reasons that you said, which is that people have fixed obligations to old capital. First of all, there are administrative problems, we think, and there are tremendous auditing requirements to try to go back in there end classify things that are sort of old and new. And we thought that would be difficult to do.

Senator **Bradley**. Why is that difficult?

Senator **Durenberger**. It is just the dates, isn't it?

Senator **Bradley**. Yes; I mean, any financing after *x* date is new; anything before that is old capital.

Dr. **Helms**. Right. It can be done, but you have to separate that out on the cost reports; and everybody would obviously have an incentive to figure out whether they can move things around a little bit, and you would have to go audit that to make sure they didn't do that; but let me make another point. The objective of a transition period is to do exactly what you said: Allow people who have fixed obligations the time to plan to get out of it. If you are worried about not giving them long enough, I think you can achieve the same thing without breaking the distinction between old and new capital—just increase your transition period a little longer for all of capital. Make the uneven a little more hospital-specific. Change the proportions a little bit. Make sure you keep the level higher.

Senator **BRADLEY**. Could you make it for more years than 5?

Dr. **HELMS**. Oh, sure. I mean, that is not set. You could make it 10 years.

Senator **BRADLEY**. Make it 15, did you say? [Laughter.]

Dr. **HELMS**. You know, that is one of the decisions that I think people are going to have to make. The longer you make it, the longer you are just going to drag it out.

Senator **BRADLEY**. Right.

Senator **DURENBERGER**. Bob, I think another reason is that the signal went out early in 1983, where there was $400 billion of prospective hospital capital investment just sort of waiting to be approved in places like New York and Minnesota and New Jersey, et cetera. The signal went out that we are changing the system. Then—and this is the point I was making earlier about why, 48 hours ago, I was very, very upset with HHS and OMB and everybody else, and now that you have a good Secretary, I have less to say—but the whole point is to get the report done by 1984 and then maybe we could have legislation by 1985 and implement it by 1986 was very carefully crafted. And there is a whole industry out there that has been sort of holding their breath, including their investors and a lot of other people, for us to make a decision about the system; but they knew it was coming. They knew that anybody who invested after January 1983 the rules were going get changed in some way, particularly those who invested sometime in March or April. So, there is a lot of new stuff on the books now that you wouldn't want to consider old and totally exempt.

Dr. **HELMS**. And that is part of the language of the 1983 act. I think it says something to the effect that they will be treated differently.

Senator **BRADLEY**. Would you know how much hospital investment there has been since 1983?

Dr. **HELMS**. No; I don't. It has been debated. I don't think, until you get the audited reports, HCFA could not tell us. There have been people who have speculated about it; some saying that it is going down, some saying it is going up that even Medicare is paying more now.

Senator **BRADLEY**. I didn't get your last point.

Dr. **HELMS**. The debate is how much is HCFA paying out in capital costs, and we will not know that until we get more audited data for more current years.

Senator **BRADLEY**. When will that be, do you think?

Ms. **MEANS**. Next spring.

Dr. **HELMS**. Yes. Next spring.

Ms. **MEANS**. We will have a sample of 1984 cost report data early next spring, but nothing more recent than that. Most of the estimates of investment activity really come from the credit markets, in terms of how many hospitals are going to the markets for financing; and those are very crude estimates.

Senator **DURENBERGER**. But there is nobody here who would have that information. All right. Why don't you finish?

Dr. **HELMS**. OK.

[Change of chart.]

Dr. **Helms**. This is just a chart to——

Senator **Durenberger**. That is a very interesting chart. It was to me the first time I saw it.

Dr. **Helms**. Yes. What we are looking at here is the Medicare capital payments for admission trended forward to 1987, and this comes from the ICF model. You have to remember that you are talking about overlapping. Each one of those groups there is taking all the hospitals and breaking them one particular way. So, a given hospital can occur in several of those classifications there; but remember that we talked about that, if you go to any kind of averaging approach, some will gain and some will lose. And what this shows here is that there is a variance in the capital payments per admission going out to different classes of hospitals. You have to keep in mind that each one of these also has variations around this average. So, we know that those hospitals—did we ever get the exact figures? Kathy says the average here is about $300, so as you can see, the investor-owned hospitals——

Senator **Durenberger**. You have used that chart once before. The next time you use that chart, put a little line on there that says "average" or something.

Dr. **Helms**. Right.

Senator **Durenberger**. That is a very important element.

Dr. **Helms**. You can see those hospitals, like investor-owned hospitals, are very near the average even though their return on equity—that little red bar at the end of the investor-owned—is to represent the proportion that they get for return on equity compared to other interest and depreciation. Starting at the top, those that have relatively large amounts of uncompensated care—of course, that category is going to overlap with the urban public hospitals down in the next part there—but they have a little bit less than the average capital payment. When you look at the next set of the three bars there; at whether they are teaching hospitals or not, those that are members of the Council of Teaching Hospitals are the large teaching hospitals; and they have relatively large capital payments, and they also have the more severe cases. So, in essence, they are doing more high technology things, and they have more equipment because they are teaching and, not surprisingly, they get more capital payments. The rural hospitals tend to get less capital payments per admission than the urban hospitals and the urban public hospitals get less than the other urban hospitals. The other urban are your not publicly owned suburban hospitals and others. If you look at investor-owned and then the public hospitals, like the county and State hospitals that are sort of lowest on the chart there, investor-owned hospitals are about at the average, and then the voluntary hospitals are a little above the average.

Senator **Durenberger**. Is the disparity there between investor-owned and some of the other public because it is old money and new money? A lot of those are very old hospitals, and they don't have a lot of capital outstanding.

Dr. **Helms**. Right. Their asset age is different. The public hospitals have older assets. The investor-owned hospitals have newer. They are located in areas which are newer and are growing faster. They are more in the Sunbelt States.

Ms. **Means**. For instance, we have a similar chart showing composite asset ages, and investor-owned hospitals are around 7 years. They are fairly new facilities, on average. Urban public are close to 17 years. So, it is dramatically different.

Senator **Bradley**. What about public, non-Federal?

Ms. **Means**. I am sorry, but those are the only two that come to mind immediately.

Senator **Bradley**. That is an interesting chart.

Ms. **Means**. Yes.

Dr. **Helms**. That is all of the charts. I would be glad to answer any other questions that you may have.

Senator **Durenberger**. I think we set a new record here this morning in terms of the length of testimony, but I would say again that I anticipated that we would take our time in sort of laying some groundwork here for other testimony that will follow. I do appreciate this, Bob and Kathy and all the other people on your team who have worked on this over the last couple of years, for the effort you have made in laying this kind of groundwork. Senator Bradley?

Senator **Bradley**. Thank you very much, Mr. Chairman. I do think that this is helpful. I didn't know, when I came, that it would be such an interesting hour, but it has been. In looking at this last chart, one of the things that occurs to me—when you look at the public hospitals and their Medicare capital payments per admission which are very low now—if you look at what has to happen in the way of capital investment in those hospitals over the next 20 years if they are going to remain able to service a community—their capital costs are going to have to go way up. Wouldn't you agree? I mean, you are dealing with hospitals have to that were built in the 1920's and 1930's; and at some point, they will have to put money into them to refurbish.

Dr. **Helms**. Right, if those particular hospitals are where Medicare people want to go. I mean, those hospitals are going to have to get out there and compete. And believe me, in terms of location and reputation, they very often can compete very well; but you are right. One of the advantages—you might say a political advantage--is that you would give these hospitals a little more gradually in capital payments.

Ms. **Means**. It would be roughly, we estimate, about a 3-percent increase in capital payments to those hospitals because they are running about——

Senator **Bradley**. But the blends—the various blends?

Ms. **Means**. That is an estimate based on ultimately having arrived at national urban and rural rates, and what they would receive under national average payment levels relative to cost reimbursement. They would receive roughly 3 percent more.

Senator **Bradley**. Thank you.

Senator **Durenberger**. Thank you. On that latter point, before I ask some other questions, I suppose the owners—if there are any owners here—of so-called public hospitals aren't going to like my answer, but it seems to me there is some advantage when you see the public costs being that low; and that is that maybe they can be talked out of some of these older facilities and into a different way of buying services for the indigent population, which originally these hospitals were designed to serve, and thus maybe free up Medicare populations in those areas to use other facilities as well. That might be one of the answers, and I realize not every community can do that; but maybe in some parts of the country, they are not losing that much as compared to some of those people who have tremendous investments. That is the problem in a lot of rural areas. They have investments in these hospitals, and as the population starts to disappear, what do they do with the hospital? Or what do they do with that investment? How do they pay it back? My first question, as I would phrase it, is: What is a hospital? How applicable is this set of information that you have provided us, to all types of facilities that are needed to deliver Medicare services? And that includes the kinds of things that used to be done in hospitals and are now being done in boxes, as some people call them. It would include a variety of nursing or rehabilitative facilities. It would extend to specialized hospitals—pediatric, psychiatric, and so forth. My question is: How applicable is this direction that you suggest we send the reimbursement system to all kinds of capital investments?

Dr. HELMS. As I tried to say earlier, we have concentrated only on adding it into the DRG system. You are asking, I think, a bigger question. I don't think that, in particular, our analysis applies to those situations because, to the extent that a hospital is now excluded from the DRG system, they would continue to be excluded. I think you are asking a bigger question about whether you could change over to some other kind of payment methodology for reimbursing specialty and outpatient facilities and so forth.

Senator DURENBERGER. I was saying that to the degree that we move the entire reimbursement system to a prospective system of some kind for the other institutions, other than hospitals. Can we use this direction you are sending us on the capital portion for all institutions? Is there anything that is hospital special about this? Why can't it be used for ambulatory surgeries in determining the capital component of a prospective system there or for SNF's or for something else?

Dr. HELMS. I suppose the principles could be used, but we have not concentrated very much on that, or hardly at all. We have tried to say: How can you include it in the DRG system for the part A hospital payment? And I guess what I am having trouble with is when you talk about a prospective payment system for these other kinds of entities, if it turns out to be something like DRG's, my answer would be: Yes you could certainly apply this. If it turns out to be some other system, not DRG's, then I am not sure to what extent this would apply.

Senator DURENBERGER. But you are supposed to have a system here, as I understand it—and I don't understand all of it—that provides us with a means of transition and then a neutral prospective approach to do this. Your objectives, and I can't go back and quote them, but it was right in the beginning of your statement, it is kind of a neutral statement. It says that the reimbursement system should not dictate debt over equity and should not dictate a certain kind of preference for certain kinds of debt or equity financing.

Dr. HELMS. Right.

Senator DURENBERGER. Put the thing in neutral. Put it in neutral as far as the part of the country you are in, and let the market in effect determine the capital decisions. Now, why if you have designed that kind of system for something we call hospitals, why wouldn't that also apply to equipment that is purchased in a medical clinic or for the clinic itself or whatever?

Dr. HELMS. Yes. But the problem I have is what is the payment unit you would use, not with the concept of being prospective. I would agree with you to the extent that this gets at the objective of being neutral. That is a worthwhile objective in these other systems. All I am saying is that this is designed to go into the DRG system, and we would have to look carefully at how to include it. But I do think it would be a worthwhile objective to achieve neutrality.

Senator DURENBERGER. Now, I have one other question that is related to that. By moving the capital reimbursement part from a hospital-specific to a cost per diem per unit, or whatever we call it, and putting it in neutral, we have an impact on the market out there—the credit market, as well, I would imagine; and that has some impact on other institutions. Do you know whether it has any kind of an adverse impact? By putting hospitals into this kind of a system, do we generate any kind of an adverse impact on other institutions vis-a-vis hospitals? Have you looked at that at all?

Dr. HELMS. We have not analyzed that specifically. I see no reason offhand why it would.

Senator DURENBERGER. I can't find any either.

Dr. HELMS. My guess is that, whatever you do with this, you are going to have some distributional effects on the credit market. I mean, some hospitals that have good marketing characteristics are going to—the people who want to write the bonds and write the financing are going to look much more carefully at what the market condition is. So, some hospitals may be favored in that capital market, and some may be hurt a little bit.

Senator DURENBERGER. Ms. Means, did you have a comment?

Ms. MEANS. Senator, one thought that occurs to me is that one of the desirable consequences, we believe, is that for those areas that have declining admissions or low occupancy, this would exert some pressure on them to convert those beds to some other use, either SNF beds or lower care unit beds—some other type of revenue-producing purpose. And I think that, in that sense, the hospital could start competing with other types of facilities, to the extent they are trying to convert their capacity to a comparable type of care.

Senator DURENBERGER. Well, I am just worrying out loud, and you are so smart that I have to ask you these questions. [Laughter.]

I am only worrying out loud about the fact that to a lot of people, yes, that pressure is going to be there. I think of rural hospitals; and I think of all the controversy in swing beds between the hospitals and the SNF's and so forth. I worry out loud, then, that some people can't make those decisions because the market for credit is still kind of high. It is very costly; and they are already paying off their investment of 2 or 3 or 4 years ago in hospital beds they haven't needed. And now the population is going way down, and the utilization is going way down; and we can say, yes, the pressure is going to be on to convert, but where do they get the money to make the conversion? That is the kind of thing I am worrying out loud about; and maybe it is not within the purview of this particular set of recommendations that flow from this, but it is certainly related to it in some way.

Ms. **Means**. One thing you should appreciate is that Bob and I and others met with a group of investment people earlier in this year and posed the question to them about what they looked for in terms of financing. There are a number of important factors, but clearly, one of the most important was the stability of overall revenues, from each of their major payment sources. They didn't look particularly at how Medicare reimburses for capital. They just wanted to know total Medicare revenues and the stability of the Medicare volume and what the hospitals' projections are, among other factors. Undoubtedly, if that is declining, that is going to place that hospital in a more difficult position in terms of converting that capacity.

Senator **Durenberger**. All right. In the area of certificate of need, 1122, and health planning, do you have some view from your analysis of this? First, maybe you can broaden my understanding of your opposition both to certificate of need and 1122. Have you run studies, done demonstrations? What kind of data is available, or is this the sort of same gut instinct that I used as an antiregulation person? Is there information out there that proves that these kinds of regulatory efforts are costly, rather than being cost efficient?

Dr. **Helms**. I think so, but of course, I have to tell you, as I am sure you are well aware—and of course, the health community argues about this a great deal—but the people that I think do good research on this, like Frank Sloane and so on, I think have proven conclusively that this costs money and there are no particular benefits. I mean, I go all the way back to publishing things at AEI years ago that showed certificate of need was not cost effective. It concentrated on beds, and the Solkeever-Bayh study said that the evidence was that it had no effect on investment per bed, but it did take money out of investing—it had no effect on total capital investment, but it took investment out of beds and put it into nonbed investment. So, I think, the more recent empirical studies of that tend to verify that. There have even been more sophisticated models, I think, done about whether planning agencies will learn to plan better; and I don't think there is much evidence that that is effective either.

Senator **Durenberger**. I was just going to ask you that. What are your personal views on community health planning, particularly as it relates to capital? My sense is that it is in transition. The whole concept is in transition; and by the Federal Government sort of kicking off the enforced concept, it has gotten at least some communities to do some creative health planning outside the structure. Is there a value, as we look ahead, to billions and billions of dollars in decisions having to be made in the community for some kind of health planning? And if so, have you thought about what the Federal role or the Medicare role might be in these sorts of facilities or the capital decisions that are made within that kind of community-based planning process?

Dr. **Helms**. I would suppose that if a community wants to do it, can, I don't want to be flippant about this; but I guess my preference is that, in terms of Federal policy, you know, there is no real justification for federally funding these activities. I personally don't have any particular objection if a community wants to get together and talk about plans and so on; but in terms of the whole economic history of regulation and other regulated industries and so on, I just have a strong preference for making the rules of the marketplace work so that people have incentives to carry out their own investments in a cost-effective way. I think that market, even in health care, could be used to work very effectively so that you don't waste resources and people. That doesn't mean that entrepreneurs aren't going to make mistakes. They do all the time; but the market has a way of punishing people who consistently make mistakes. Kathy pointed out to me that communities may have certain preferences about how to plan for care of certain kinds of people that they don't think are being taken care of with Government programs; and we are very supportive of local activities to take care of people. So, to the extent that you want to call that health planning at the community level to really get into those kinds of things—what I object to is the market entry kind of regulation. It just tells an entrepreneur that you must keep your excess capacity there. You are not allowed to get rid of it; or if you have a better idea, you can't get into the market.

Senator **Durenberger**. But I have already alluded to the fact, and you have, too, in your statement, that past Federal policies have placed, for some period of time, impediments in the way of the market working. You talked about the Hill-Burton problem. It has saddled a lot of these communities and they asked for it; but we can't blame them. They have been saddled with big investments. Every little town in my State that has a chamber of commerce office in the high school has a hospital. Nobody is using it, but they are paying for it. We talked about 242. We talked about a variety of other things. Decisions haven't been made on a market basis. I watched the struggle, say, in Maryland, which is very interesting. I used to attack them, and now I sort of sit there and watch what they are doing. They are trying to come to grips with these things; and I wonder if we can just totally stand aside from that process and not encourage it in some way.

Still, as I think about the Reagan urban policy, summed up in three words, I guess: Urban enterprise zone. You know, if that isn't telling a community that the Federal Government will spend billions of dollars in your community by way of tax forgiven or tax revenue foregone, if you do certain things, that is community planning. We are just telling them that we are going to reward them for that sort of thing. So, I vote for that around here, but I don't feel very strongly about it because I think the market ought to work; but I think it comes about because of past Federal policies that have put impediments in the way of that kind of community development. Anyway, maybe you have answered it from your viewpoint, and maybe I am just suggesting that we both think about it a little bit as we move farther into this area.

Let me ask you a couple other questions about your personal suggestions, and we will keep this separate and apart from what HHS has recommended. And as a prelude to that, I understand that the report went from HHS to OMB last week—sometime about a week ago—and I have talked to Jim Miller; and obviously, he wasn't in any position to grind out an approval. It would have been wonderful if he could have, but it is also probably a good thing that he didn't. Jim and I are going to get together in the next week or so and talk about this and some of the other things. We are also going to have a hearing in the Intergovernmental Relations Subcommittee on the role of OMB in the regulatory process as well; and hopefully, maybe the future will be a little smoother in terms of some of these relationships. But I don't want to get into the specific recommendations; but I would like to concentrate on what your own instincts tell you in terms of your analysis, with a set of questions that go as follows. What would be your goal in incorporating the capital payment in the DRG rate? I know, in part, you stated that in the statement, but that was an official statement. Do you agree with that statement personally?

Dr. **Helms**. Yes, very much so. I think from the time we started analyzing this thing, I think one of our objectives was to make it consistent with the incentives in prospective payment and turn that incentive back over to the hospital manager.

Senator **Durenberger**. Let me ask you then about your instincts on transition, if they vary from this presentation at all. My bill has a relatively short period of time, and we have talked here about other years. Particularly when you look at the different types of hospitals and how they might be affected by a transition, and keeping in mind that I think you are recommending to us and the Department, I take it, is recommending to us that we go to a national average and that we continue to go to a national average on the operating side. We would end up with a national average that has only the urban-rural split in it, and as you pointed out here, the labor-nonlabor component; but given all of that, what do your personal instincts tell you about transition? Should we not worry too much about the folks who already have their money invested and really concentrate more of our effort on the next investment that is made and the future investment? Should I spend a lot of time thinking about transition, or should I not worry much about transition and think more about the design of the system as it applies to the next decision that is taken on capital investments?

Dr. **Helms**. I don't quite draw that distinction. First, let me go back and say I do think you need to think seriously about a transition, and I am trying to speak as an economist, not just politically. I mean, the people who have high capital hospitals are going to very identifiable hospitals. I mean, they are located pretty much around the country, so they are——

Senator **Durenberger**. They are all in congressional districts and Senate districts, and things like that.

Dr. **Helms**. That is what I am getting at right now. [Laughter.]

Ms. **Means**. All 400 of them.

Dr. **Helms**. And so, those particular hospitals will have a particular stake in how you transition this thing in. So, my personal feeling is that, to do it without a transition, I think would just be very disruptive. My personal preference is that you have a transition and that you keep it on the long side. If I have to choose, I am going to keep it on the long side, but I think that would just be my recommendation; but I don't extend that. Quite frankly, there is no analytical way to pick the right number of years that I know of. I think that if you extent it out too far, say past 10 years, you have to start asking: Why extend it out that far? I mean, if you are going to do that, let's get at it. But when you are asking if we should start worrying about the next decisions, I think one of the analytical objectives of going to this system and being fair about it with a relative number of years—say 5 to 10 years or something like that—that you are going to create a situation that the hospital knows already fairly well in a prospective sense what they are going to be paid for DRG; and since their case mixes don't vary a lot, or they vary in predictable ways, they already had a fair projection of prospectively what they are going to get out of Medicare. If we finalize the capital policy, the hospital manager will also be able to know how many years it is going to be, where they stand in the transition, what the blending is going to be. So, I think they will be able to get a fairly good picture of their future revenue stream. They can then look out there and start thinking about the next decision. I mean, this thing will force them to do that, not after 10 years or 5 years or 7 years, or whatever we pick, but today because any manager who has to be thinking about capital has got to be thinking about long-term investments.

Senator Durenberger. Now, let me ask you a couple of related questions. If you are that hospital administrator or president in, say, Phoenix, and you know you have 80,000 people coming into this community—new people—every year, and every year you have been making some new kind of investment, is that a distinguishable group of hospitals that ought to ' e treated any differently? For example, suppose you are running a major teaching hospital—one of the folks that are on this side of the blip in the 300—and you have been forced in one way or another to make major investments in recent years, and you are very confused about where we are going in graduate medical education, and we are playing around with indirect teaching all the time; and you have heard about the surplus of the 300,000 doctors or whatever it is by the year 2000. You are, just confused as hell about what your role is going to be in the future. Or you may be in an identifiable category of people who may not be in transition and may be treated somewhat differently. And the third case I think of is in the gray area between the urban-rural distinction. It is the larger towns that are not in the big city category. In my State, you know, it is not the Twin Cities I am talking about. It is towns like Willmar and Marshall, and even, I suppose, you might talk about a Fargo, ND, which is a pretty big city, but in a larger context.

Now, what is happening to those hospitals is that, with the large change in those little hospitals all around them within 150 miles or maybe 100 miles of these hospitals, all these little hospitals are going down in one way or another. So, there is this competition going on between these larger city hospitals to get that business; and we don't know what the case mix is going to be for those kinds of hospitals. Is there any reason why we shouldn't put a little thinking time against the urban-rural distinction to try to facilitate that decisionmaking process that the Fargos, Moorheads, and Duluth, MN, and people like that have to go through?

Dr. HELMS. Yes. Let me go back to a statement when we met with these financial people. They were just making the point to us that there are a lot of hospitals out there that are in financial trouble; and they are not the only people who have said this, but they are critical of the fact that some of them are in trouble because they have had bad management and so on. I mean, you take an industry with over 6,000 hospitals, and you are going to get a wide variety of management styles and so on, and some of them will be in trouble. The point they were making was that, whatever we did with capital, it was not going to save some of these people. I mean, there are larger market forces at play; and you couldn't really protect them; or you wouldn't make much difference at the margin of whatever Medicare did with its capital payments, that these people were in trouble for more fundamental reasons, and they were going to continue to be. So, I think in a sense we could look at the urban-rural distinction, but I guess maybe one of the philosophies behind this thing of capital and getting out of planning is that the Government doesn't have any particular expertise to second-guess this market better than anybody else. What we are doing is putting—I hate to get philosophical about this, but the whole case against planning is that a market system works on the basis of individual decisions; and what is important is to make sure the managers of those hospitals to the best of their ability know what the market situation is and plan accordingly. That is my very abstract answer to your concern.

Senator DURENBERGER. Do you have that same view with regard to the teaching hospitals?

Dr. HELMS. I think so, but there are some other issues there. You know, the Federal Government is subsidizing research and so on in other ways, and I think again the abstract answer to that is that prospective payment and a lot of other market forces are making what used to be a lot of cross-subsidies very apparent. It is not just Medicare and so on; it is the private payor who doesn't want to pay for a lot of this now; and it is putting pressure on the big teaching hospitals. So, we have a big study going on about that now, which I hope to get out some time in the spring, which is about the cost of graduate medical education. I think we have some future decisions to make about it. In terms of capital, I think if you go with the total revenue approach, and you have a reasonable transition period, you are going to be fair to those people. So, I would not be personally inclined to make some exceptions for the teaching hospitals.

Senator DURENBERGER. All right. I have a couple of other questions here. How would you distribute the capital payment across the DRG weights? You personally.

Dr. HELMS. We think it has already been done. When they recalibrated the DRG weights on the basis of charges, that really includes capital in it. And I think you could do that technical job, but not since MCFA has already done the analysis. Do you do them every 4 years or so when you do them?

Ms. MEANS. As you know, the current law provides that we recalibrate not less often than every 4 years, that is, recalibrate the

DRG weights. The current set of weights that went into effect October 1 are based on hospitals' total charges, and we believe that their capital expenses are implicit in those total charges. However, it would be possible for us in future years, even next year, to recalibrate on the basis of cost, including capital cost, if that was the desired policy decision. The only question at that point then would be the currency of the cost information we would have available to recalibrate the weights. We would want to make sure that the hospital costs we were using were reflective of their experience under prospective payments and not prior periods.

Senator DURENBERGER. What update factor would you use to modify the capital component of the DRG payment for the transition and after the capital portion has been completely incorporated in the DRG?

Dr. HELMS. As I think I discussed a little bit before, we think this is possible to do, putting some capital components into the market basket; and you would use those. But as I said before, I would not expect those to vary much from the general rate of inflation, which is true of any broad index. So, you could use just the capital part of that to update capital, or you could use the total thing to update the total cost.

Senator DURENBERGER. How would you define budget neutrality over the period of a transition to an all inclusive DRG rate, assuming we wanted the capital payment restructuring to be relatively neutral, considering what Medicare would have spent for capital if the passthrough had continued? Do you understand that? I don't. [Laughter.]

Dr. HELMS. I understand it enough to say that I had better be careful. [Laughter.]

I think there is some debate about that. We have certainly not reached any decisions about it; but one way you could interpret that is to try to pay what you would estimate what would have been paid under the cost-based reimbursement, and then distribute the money on the basis of hospital-specific and national rates.

Senator DURENBERGER. All right. I think this was a Gramm-Rudman question—this last one. There are ways to save money for the budget from a new capital payment policy. What would you suggest if our goal was to do the least harm to the hospitals in cutbacks from capital expenditures under Medicare? In other words, where would you go if you were a secretary or if you were Phil Gramm, to save money for the budget in the area of capital?

Dr. HELMS. I will answer that because I do have views about it. I think it is going to be a tough choice about where you get all these savings and how much you do the cutting; but my preference is that, if this policy that we have outlined for capital has all the advantages we have said and it is worth doing, we should leave it alone, not to slash it as a budget item. And believe me, to be fair to Jim Miller and the people at OMB, I am sure they have differences of opinion about this; but I would prefer to go after the cuts in the DRG updates. My objective is to be able to establish a good capital payment policy, get it in place, and create the right kind of incentives. Then, if the Congress decides that we must have enormous cuts inside of Medicare, they should come more across the board in the DRG updates. That is where the money is; and so, that is my preference.

Senator **Durenberger**. But that is the same theory on which we sold the other 93 percent. We said to the hospitals and the doctors: If you buy into this change from cost-based reimbursement to this puny, little adjustment called the market basket and if you buy into the theory that we are going to let the Secretary of HHS play around with that market basket, you know, we won't touch you. I know you haven't got a lot of choices here—if it is one or the other—but your answer relative to capital would be my answer relative to the operating side.

Dr. **Helms**. If you accept that, then your choice is not to cut Medicare and look for it elsewhere.

Senator **Durenberger**. Thank you. [Laughter.]

We are on the same side. It has been suggested that Medicare ought to reduce its capital payments if hospitals consistently operate at Occupancy levels below a given threshold. My question is this: What is your view of this approach of constraining capital costs? And if you like it, how would you implement it, and what effect might it have on the marketplace? And is it an appropriate method to get some budget savings.

Dr. **Helms**. I don't like it, and I would like to think that maybe that suggestion has gone away; but it may come back in the sense of whether or not you wanted to adjust because you think there is excess capacity. You could use it as a way of sort of setting the lower level of payment. I object to trying to do it on a hospital-specific basis because I think it would be enormously regulatory and complex to figure it all out and to do it that way. And, also, I think it would particularly hit a lot of the rural hospitals that you are concerned about. They are already in financial trouble, and it would really hit them the hardest.

Ms. **Means**. We also think that this approach achieves eliminating Medicare subsidy of idle capacity over time. As you gradually move toward the national average rate over the course of the transition period, you in effect are also gradually moving Medicare out of subsidizing the low volume hospitals that have excess capacity. So, you achieve the same results, just more slowly, than if you were to reflect that in your upfront, goingin level of payment.

Senator **Durenberger**. All right. There seems to be some suggestion out there, fairly substantial I know on the House side, that return on equity as a part of the Medicare payment should be dropped completely or phased out. My question is this: Do you think that hospitals that fund capital expenses through equity financing should receive the return on that investment to cover the opportunity costs with the investment?

Dr. **Helms**. Let me put it this way. I am almost certain that they will probably adopt a policy that agrees with the House, suggesting that it be taken out. The question is—I would support taking it out eventually, but I would oppose taking it out of the hospital-specific during the phasein because, to me, it just goes against the principle. If you are doing a transition and you are having an uneven phasein or an even phasein, to be fair to the people who have fixed obligations, I wouldn't think it is particularly fair to take it out. If you are going to have hospital-specific and you are going to say the objective of a transition is to ease them out, then it applies to those payments also. That is very much a personal opinion, and within the Government there is lots of disagreement on that.

Senator **DURENBERGER**. Do you know whether there is sufficient funding in the pool on money which will be paid out in the addin to cover legitimate ROE, assuming the current ROE is dropped?

Dr. **HELMS**. I can't answer that precisely, as to whether there is enough money to make up for it. I think several people are going around saying that the for-profit sector has one of the most profitable sectors of the hospitals, and they already have very strong incentives under the prospective payment and will have under the total revenue effect to make a profit. So, you don't need to worry about it. I don't have any precise analytical answer that there is enough money there, if that is your question.

Ms. **MEANS**. Senator, one of the things that started us thinking in a total revenue standpoint to begin with was the fact that all of these profitability judgments relative to the DRG payments should not be made just relative to capital revenues. Not to single out investor-owned hospitals, but just the basic information we have suggests that they have lower than average operating costs and are probably profiting relative to the operating payment. So, if you want to think about their ability to profit under the system, I think it is important to think in terms of the total prospective payment and not just a particular item, like return on equity.

Senator **DURENBERGER**. Yes; one last question, which relates to 1559. In our bill, we used an addon to the DRG rate, and you have suggested that capital be incorporated in the rate itself. What exactly is the difference between those two approaches, and why is your suggestion about the all-inclusive rate preferable to our addon?

Dr. **HELMS**. We, in essence, use an addon during the transition, but we would just say that to perpetuate that, as you would do with adding on a certain percent to each DRG forever, it makes you go through this mental exercise of keeping the separation of operating and capital costs; and that just has some administrative problems which we don't think is particularly necessary to do.

Ms. **MEANS**. One of the other concerns is that, in the future, at the end of the transition period, we could potentially—although it would be premature to say that this is a decision—just rebase the entire system on some measure, hospital cost or some other measure, 5, or 6, or 7 years out. In that way, we would be paying a genuinely total revenue payment where you no longer distinguish between capital and operating costs. If you keep a percent addon, you also perpetuate possibly an annual dispute about the level of that percent addon. That could be an annual——

Senator **DURENBERGER**. All right. I think that covers what needs to be asked right now. If there are some questions that need to be incorporated, we will ask you to submit the responses in writing. I will just close then by expressing my appreciation to both of you one more time and, Bob, to you in particular, for handling the situation well in terms of giving us some advice that will be very helpful to us as we continue to move through this process, and I think in the larger community that was represented here today, too.

Your willingness to come here under these circumstances is going to be very beneficial to all of us. So, thank you very much.

Dr. **Helms**. We appreciate your leadership and interest in it, too, Senator.

[The prepared written statement of Dr. Helms and answers to questions asked by Senator Packwood follow:]

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of the Secretary
Washington, D.C. 20201

STATEMENT BY

ROBERT B. HELMS, PH.D.
ACTING ASSISTANT SECRETARY
FOR PLANNING AND EVALUATION

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
UNITED STATES SENATE

NOVEMBER 8, 1985

Mr. Chairman, Members of the Subcommittee:

I am pleased to be here this morning to discuss the issues and options involved in Medicare payments for hospitals' capital-related costs.

BACKGROUND

Currently, Medicare pays, on a "reasonable cost" basis, for depreciation on plant, buildings and equipment, for interest expense on capital indebtedness, and for a return on equity capital to investor-owned hospitals.

In establishing the Medicare hospital prospective payment system (PPS) with the enactment of the Social Security Amendments of 1983, the Congress deferred action on incorporating capital-related costs into the system until October 1986. The law stipulates that, if further capital-related legislation is not enacted by October 1, 1986, cost reimbursement for capital expenditures will be subject to review and approval under mandatory Section 1122 health planning agreements between the Department of Health and Human Services and the States.

The interim decision by the Congress to continue cost-based reimbursement of capital-related expenses was based on the recognition that further study was desirable before these costs could be incorporated into the prospective payment system. Thus, the law required that the Secretary of HHS study capital-related costs and report to Congress on options for incorporating capital into the prospective payment system. Report language directed that:

- the capital study be comprehensive and explore all options, "including broadening the DRG payment to include a capital component, establishment of limits modeled on section 223 applicable to capital costs only, and the setting of limits on a statewide basis;" and that
- the report include specific recommendations "on the method and proposals for legislation by which capital-related costs, such as return on net equity... can be included within the prospective payment amounts."

Within the Department, the Office of the Assistant Secretary for Planning and Evaluation was given the responsibility to study capital payment issues and to prepare the report to Congress. We have drawn information and options from interested groups and individuals, commissioned a number of special studies, and internally conducted extensive analyses of issues. Our criteria for evaluating various options and proposals include their consistency with goals of administrative simplicity, predictability of payment, and incentives for efficiency and flexibility in hospital management.

In July 1983, we sought written contributions from major interest groups concerned with hospital capital policy. Over the last year, we received speciic proposals from seven groups:

- American Hospital Association
- Healthcare Financial Management Association
- National Committee for Quality Health Care
- Washington Business Group on Health
- Protestant Hospital Association
- American Health Planning Association
- National Council on Health Planning and Development

Five more groups submitted principles or comments. We considered each of them carefully as we analyzed options in preparing the mandated report. We have also shared with Congressional staff and representatives the following background studies performed under contracts and grants:

- The Status of Major State Policies Affecting Hospital Capital Investment, by the Intergovernmental Health Policy Project;
- Approaches to Setting the Level of Payment for Hospital Capital Costs Under a Prospective Payment System, by Harold A. Cohen and Jack C. Keane;
- Historical Trends in Hospital Capital Investment, by Brian Kinkead;
- Capital Payment Policies in Other Industries: Lessons for Hospitals, by Frank Sloan;
- Financing the Hospital: The Experience Abroad, by Uwe Reinhardt; and
- Treatment of Capital Costs in Four Medicare-Waivered

States: Maryland, New Jersey, New York and Massachusetts, by Jerry Cromwell and others at the Center for Health Economics Research.

In addition, HHS staff has performed considerable analyses in-house, including working with a model developed by ICF, Inc. that simulates the effects of various Federal and State capital-related policies on hospital investment behavior.

Following the legislative mandate to address only the inpatient portion of hospital costs, our analysis does not encompass options for the payment of capital associated with outpatient services, nor does it address capital payment policy for skilled nursing facilities. These services have unique characteristics that dictate separate analyses of payment policies and options.

HOSPITAL CAPITAL INVESTMENT TRENDS

Between 1946 and 1981, annual medical facility construction increased by some 365 percent, from $200 million to $7.5 billion. This growth in post-war construction was largely attributed to two major developments in the hospital industry, the Hill-Burton program and the expansion of private health insurance.

Prior to World War II, the primary source of capital and operating funds for the hospital industry was derived from philanthropy and patient revenues. With the predicted gap between the nation's existing supply of hospitals and the projected future needs, the Hill-Burton program was enacted into law in 1946 to provide a major source of capital in the post-war years for the construction of voluntary and public hospitals and nursing homes.

The second major factor that provided impetus to improvement of the capital position of hospitals was the emergence of private insurance, which greatly improved public and church-affiliated hospitals' equity position and access to debt financing. Recognition of capital as a legitimate operating expense by third-party payers enabled many hospitals to fund depreciation and interest costs and build internal reserves.

With the enactment of Medicare and Medicaid, the increased demand and revenues resulting from these programs provided the basis for a rapid expansion of hospital capacity and modernization of equipment and plant. This growth in both public and private revenues for hospitals had the overall effect of adding stability to hospital revenues and of reducing the level of risk associated with hospital investment, making capital expansion of investor-owned hospitals more attractive to investors.

With the establishment of mortgage loan and insurance programs for voluntary and investor-owned hospitals under Section 242 of the Federal Housing Act, hospitals' access to debt financing for capital expenditures improved dramatically. The most important factor that enabled many hospitals to debt finance was the emergence of tax-exempt revenue bonds. Between 1971 and

1977, tax-exempt financing increased at an average annual rate of 52 percent, adjusted for inflation.

The growth of multi-hospital chains was one byproduct of the expansion of debt financing. With the increasing dependence on debt capital, the incentive emerged for hospitals to pool their revenues to gain more favorable access to the credit markets and consequently lower the effective interest rate they paid. Multi-hospital chains were attractive because affiliations provide a larger base of operations over which to spread debt service costs. The invester-owned segment of the industry was particularly aggressive in taking advantage of multi-hospital affiliations; their incorporation into chains increased by 48 percent between 1976 and 1981.

From the mid-1970s to 1980, hospital capital investment declined in real terms. Though many reasons have been suggested for this decline especially given the unprecedented levels of capital spending of 1971 and 1972, that hospital capital spending established an equilibrium point, closer to the "normal" level of investment required to replace and modernize existing assets. For the future, there is a fair amount of variation cited in the literature with respect to the estimates of hospital capital requirements.

THE ROLE OF OTHER FEDERAL POLICIES

In recent years, Federal tax policy has come to play an important role in shaping hospital investment strategies. Under current Internal Revenue Service codes, tax-exempt financing is available to non-profit hospitals qualifying under the provisions of Section 501(c)(3). Under these provisions, investors in eligible hospitals are exempt from taxes on the interest derived from bonds issued on behalf of the hospital. A total of 26 States currently have authorities or agencies which can issue tax-exempt revenue bonds for non-profit health care facilities.

Though tax-exempt bonds have emerged as a mechanism of choice for the non-profit hospitals, one effect of this provision in the tax codes has been the loss of revenues to the U.S. Treasury as a result of the proliferation of this form of financing. Between 1968 and 1983, the proportion of non-profit hospital investment financed by debt of all kinds increased from 40 percent to 60 percent. In 1968, the majority of this debt was subject to Federal tax. By 1983, however, well over 80 percent was tax-exempt, resulting in an estimated tax subsidy of $2.4 billion in Federal taxes in FY 1986.

Another Federal program vital to hospital capital investment has been Section 242 of the Federal Housing Act which insures the mortgages which finance hospital construction, modernization, and renovation projects for up to 90 percent of the replacement cost of the project. As of the end of 1984, 226 mortgages had been insured at a total value of $4.2 billion. Though hospitals are able under this program to obtain loans at somewhat lower interest rates, the overall effect of the program is to encourage debt-financing.

A third major Federal program with a direct impact on capital investment was the certificate of need (CON) program as authorized by the National Health Planning and Resource Development Act of 1974. This Act required all States to establish CON programs to review and approve capital expenditures in plant and equipment proposed by institutional health facilities. CON is a form of market entry regulation which was believed to prevent duplication and reduce excess capacity, thus helping to contain overall system costs. Its effectiveness has been questioned for a number of reasons. Based on previous experience with public utility regulation, there is the possibility of "capture" by the regulated industry. Also, limiting capacity can effectively grant franchises to existing facilities and preclude entry by more efficient competitors. Thus CON hampers the operation of competitive markets in the planning and construction of hospital beds--beds are built where they may not be needed, and areas that need beds may be unable to build them. Also, even in the face of declining admissions, hospitals are reluctant to de-certify beds in the fear that they could not re-open them if trends shifted.

Two years before the enactment of CON, Section 1122 was added to the Medicare and Medicaid statutes by the Social Security Amendments of 1972. Under Section 1122, the Secretary is authorized to withhold Medicare and Medicaid reimbursement for the capital costs of a project that a designated State planning agency finds is inconsistent with its own standards. Although Section 1122 is similar in structure to CON, in operation it is quite different. While CON regulates market entry, Section 1122 functions as a reimbursement control. A further distinction is that State participation in the 1122 program is optional, with only 16 States and the Virgin Islands currently participating. The 1983 Social Security Amendments specify that 1122 approval will be required in all States if capital is not included into the prospective payment system.

Many believe that there are compelling arguments to eliminate both 1122 and CON to save funds and to generally reduce regulatory burden. Both programs have proven ineffective in controlling overall hospital costs.

CURRENT PRACTICES AND PROBLEMS IN MEDICARE CAPITAL REIMBURSEMENT

Until the enactment of the prospective payment law, hospitals were reimbursed for the "reasonable direct and indirect costs" of providing covered services. Under the reasonable cost principles of reimbursement, capital costs have been reimbursed in the same manner that they were when the original enabling laws were enacted in 1965, including payment for depreciation on physical plant, buildings and equipment, for interest expense on capital indebtedness, and for a return on equity capital to investor-owned hospitals.

The cost pass-through for capital retains all of the problems that had initially prompted the prospective payment system for operating costs, that is, inappropriate incentives for hospitals, detailed cost reporting requirements, and payment levels that are difficult to predict for budget purposes. In reimbursing an individual hospital its incurred costs for capital expenditures, Medicare makes depreciation payments and shares in the interest expense associated with the cost of financing capital investments. This policy insulates hospitals from the financial risk of a poorly conceived or timed investment. Cost reimbursement also fails to provide incentives for hospital management to minimize the overall cost of new investments.

Under cost-based reimbursement Medicare payment amounts for capital to individual hospitals are influenced by three factors: the hospital's actual spending level for capital, the value of its current assets, and its share of Medicare patient days as a percent of total patient days, regardless of whether total bed capacity is excessive relative to its occupancy rate. Thus the payments are not directly related to a hospital's actual Medicare patient volume and the needs of its varying patient case-mix. This means that there are large disparities in Medicare payments for capital to different classes of hospitals for reasons unrelated to the care of Medicare patients.

For example, Medicare makes high capital payments, on average, to many hospitals primarily because those hospitals are creditworthy, have good access to capital markets, and tend to invest heavily in capital inputs. In contrast, Medicare makes low capital payments, on average, to other types of hospitals, such as large, urban public hospitals, primarily because they are less creditworthy, less able to obtain financing for capital investment and direct most of their financial resources into subsidizing other operating expenses.

MEDICARE CAPITAL PAYMENT OPTIONS

The Medicare prospective payment system is sufficiently flexible to accomodate payment for hospital capital costs under a variety of methods. The basic choices in methods of payment for capital-related costs are cost-based reimbursement and incorporating payment for capital into the average, prospective payment rates. Many methodological variations are possible under each alternative. For instance, one could modify cost reimbursement to include either reimbursement limits or health planning controls. Before discussing these variations, however, there are fundamental aspects of cost reimbursement for capital that are common to and underlie each of these options and which must be understood.

Cost-Based Payment

Cost reimbursement for capital contains many of the undesirable elements that cost reimbursement for operating expenses did and that originally prompted the creation of the prospective payment system. These problems relate primarily to undesirable incentives that encourage excessive spending on capital and result in maldistribution of Medicare payments for capital.

Under cost reimbursement, the Medicare program basically reimburses a hospital its actual incurred costs of capital investment without regard to whether that investment (a) is necessary, (b) contributes appropriately to efficiency of operation, or (c) was financed in an optimal manner. Payment amounts to individual hospitals are directly related to a hospital's rate of and spending levels for capital investment. As a hospital's spending level on capital increases, so does its Medicare capital-related payments, assuming constant Medicare occupancy. Cost reimbursement does not foster prudent hospital capital investment behavior.

The current split of DRG payments for operating expenses and cost reimbursement for capital creates a positive incentive for hospitals to substitute capital for labor, perhaps inappropriately from an efficiency standpoint. While hospital decisions to invest in capital rather than labor may be appropriate in some instances, the Medicare payment system should be neutral with respect to such decisions and not foster one category of input over another.

The present cost reimbursement policy could be continued for capitol-related expenses in conjunction with health planning programs such as certificate-of-need or Section 1122. These programs, however, have not been demonstrably effective in counteracting the powerful financial incentives for capital investment. It is ineffective and intrusive for regulatory bodies to attempt to pit their judgments against those of hospital managers with respect to the overall necessity and appropriateness of specific expenditures. Of necessity, only the most obviously inappropriate expenditures are likely to be prevented or curtailed. Health planning has not and is unlikely ever to be as effective in inducing desirable cost-conscious behavior as would the careful restructuring of the payment system of a major payer, such as Medicare.

Application of Section 223-type cost limits to the current capital payment method was mentioned as an option to be considered in the House of Representative's Ways and Means Committee Report accompanying the Social Security Amendments of 1983. Under this approach, hospitals could be sorted into peer groups according to variables such as geographic location and bed-size, and a maximum payment limit on hospital-specific capital reimbursement could be set at some percent of the mean capital cost for each group. The capital costs of each hospital used for calculating the group limit would be defined through reasonable cost principles. This approach would have the effect of limiting capital payments to hospitals with especially high capital costs. If the limits were not too stringent, a range of payment levels would still be available to individual hospitals below the limit and payments would not be frozen relative to a high or low point in hospitals' cycles.

This concept is a very problematic approach to apply to capital costs. Capital costs can vary tremendously over time for a particular hospital, depending on its overall average level of investment in capital or on whether it has recently undertaken a major investment. High capital costs in any given period may simply reflect a recent major investment and bear no relation to whether or not the hospital is operated efficiently.

In addition, there are problems associated with determining an appropriate basic unit around which capital costs should be calculated and reimbursement limits imposed (i.e., per case, per bed, or per bed adjusted to a target occupancy level). There are administrative and equity problems related to both prospectively and retroactively applied cost limits. Any Section 223 limit approach involves continuation of a cost reporting system to provide the data base upon which cost limits can be developed and applied.

Average Payment Method

Given the basic design of the prospective payment system, any approach that incorporates payment for capital into the system, by definition, entails averaging. There are two general mechanisms for implementing an average payment method: a uniform percent add-on and an all-inclusive rate.

Each of these approaches would require decisions on the following elements of a payment method: the mechanism by which payment is made; the average payment level; a transitional period to move from hospital-specific payments to average payments; the distribution of capital inputs across DRG weights; and a factor for updating prospective payment amounts that reflects capital as well as operating expenses. One should also consider the relationship of capital payment policy to the CON and 1122 rograms. The next order of decisions include:

- Mechanism: All-inclusive rate or percent add-on.
- Level: Involves judgements regarding appropriateness of currently allowable costs, such as return on equity payments to invester-owned hospitals.
- Transition: Involves decisions on:
  - length (for example, 5-10 years)

- blending proportions for the federal versus hospital-specific portion of the capital rate
- choice of cost reporting base for hospital-specific portion of the payment, that is, should it be fixed at a base period or allowed to change over time.

Incorporating capital into DRG-based payments would break the link that currently relates Medicare revenues for capital to the value of a hospital's current capital assets. That is, high rates of investment in capital (i.e., a high asset base) generates high capital-related revenues, while a low capital asset base generates low cost-based revenues. The latter is a problem particularly for chronically undercapitalized hospitals such as large, urban public hospitals with old and deteriorating physical plants. Cost reimbursement from Medicare or other payers does not generate revenues sufficient to permit such hospitals to improve their capital stock unless supplemented by other revenue sources.

The percentage add-on and all-inclusive rate mechanisms share these advantages, and either would be a marked improvement over the current cost-based system with or without controls. However, there is an important difference between the two methods. The percent add-on method would perpetuate the current practice of distinguishing between Medicare capital and Medicare operating payments, whereas the all-inclusive rate method would eliminate the distinction by creating an all-inclusive prospective rate that would provide hospitals a total revenue amount for treating Medicare beneficiaries.

The most important aspect of incorporating capital into DRG-based payments could be that Medicare payments would be linked to Medicare volume and case-mix rather than to a hospital's total fixed costs, which may be excessive (due to either spending levels or unused capacity, or both).

Both mechanisms require a transition period to ease the impact on hospitals that are currently highly leveraged with respect to capital investment into the average payment rate system. This transition would be similar to the one currently used to implement PPS. In the area of capital hospitals are less able to respond quickly to significant changes in payments for capital due to the sizable, longer-term and relatively fixed aspects of the costs involved.

In light of the inefficiencies and disparities inherent in the current cost reimbursement method of Medicare payments for capital-related hospital costs, I believe that a total revenue-average payment approach represents a major step forward to a unified, coherent Medicare payment policy for the hospital industry. Such an approach could stimulate desirable changes with respect to the future levels and distribution of capital investment. We are currently in the process of developing the more detailed specifications to implement this recommendation.

CONCLUSION

Our recommendation is designed to incorporate an average amount for capital directly into the DRG payments. Thus, when implemented, all participating PPS hospitals will be paid on an average, rather than hospital-specific, basis for capital as well as operating costs. This approach complements the incentives for efficiency of the prospective payment system for operating costs. It unifies the rate structure and leaves the payment incentives neutral with respect to operating versus capital decisions made by hospital management. It encourages hospitals to make capital investment decisions which are sensitive to market conditions.

Linking the flow of Medicare capital dollars to Medicare admissions and case-mix means that the distribution of Medicare capital payments becomes self-regulating. That is, those hospitals that compete successfully for Medicare patients and those areas of the country where Medicare beneficiaries are concentrated and use inpatient hospital services, will automatically receive additional Medicare payment for capital as their Medicare volume increases. Correspondingly, those hospitals and areas that serve low numbers of Medicare patients and that have overall low occupancy levels (unused capacity) will experience an appropriate decline in Medicare payment when this policy is implemented.

Certain classes of hospitals that have invested at levels lower than the national average will, to the extent they retain Medicare volume, experience a increase in average Medicare payments. Other classes of hospitals may experience a decline in overall average Medicare payments for capital. Since the ultimate goal of this approach is to eliminate the distinction between capital and operating payments, the test for hospitals will become one of evaluating the total cost of serving Medicare patients relative to total Medicare revenues, with each hospital free to choose the optimal mix of capital and other inputs in providing that care.

Given the relative magnitude of Medicare revenues to total hospital revenues, and the incentives of the prospective payment system for cost-conscious behavior, a highly regulatory health planning apparatus would not be necessary under an approach that incorporates an average payment for capital. When a refined system is implemented, the financial discipline imposed by the prospective payment system could have considerably more profound and desirable effects than market entry regulation or post-hoc reimbursement penalties.

This concludes my prepared remarks, Mr. Chairman. I will be happy to answer your questions and those from other members of the Committee.

BOB PACKWOOD OREGON CHAIRMAN

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United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510

November 18, 1985

Robert B. Helms, Ph.D.
Acting Assistant Secretary
for Planning Evaluation
Department of Health and Human Services
200 Independence Avenue, S.W.
Room 415F
Washington, D.C. 20201

Dear Dr. Helms:

To follow-up on your testimony at the November 8, 1985, Subcommittee on Health hearing regarding hospital capital cost reimbursement under the Medicare program, Senator Packwood would like for you to answer the attached questions.

Your response should be typed on letter-sized paper and double spaced. To meet our printing schedule, please provide your answers no later than December 16, 1985. Send your response to:

United States Senate
Committee on Finance
Attention: Shannon Salmon
Washington, D.C. 20510

If you have any questions, Ms. Salmon can be reached at 202-224-4515.

Sincerely yours,

EDMUND J. MIHALSKI, C.P.A.
Deputy Chief of Staff
for Health Policy

EJM:crm

Question 1.—S. 1559 would include an add-on percentage factor to the DRG rate in lieu of current capital cost pass-throughs. You have suggested that instead of an add-on factor, a Medicare capital allowance could be incorporated into the DRG rate, itself.

What is the difference between the two approaches?

What are the advantages and disadvantages of each approach?

Response to question 1.—The difference between a capital add-on factor and a capital allowance that is incorporated into the DRG rate is subtle but significant. The add-on approach would perpetuate the current distinction between capital and operating costs and would require that each cost component be tracked closely in order to determine any changes in their relative shares of the total over time. In contrast, an all-inclusive DRG rate that incorporates capital expenses eliminates the need to ascertain the relative proportions of capital and operating costs so precisely.

Both alternatives share many advantages over the present cost-based reimbursement policy for capital. Most importantly, an average capital payment approach such as either the add-on or the all-inclusive rate mechanism would break the link that now relates Medicare revenues for capital to the value of a hospital's current capital assets. Instead, Medicare payments for capital would be linked to Medicare volume and case-mix. Thus hospitals with a large Medicare patient load would receive commensurate capital payments and those hospitals with large (possibly excessive) fixed costs but low Medicare volume would receive lower payments for capital than at present.

Question 2.—Many hospitals across the country are in the process of replacing buildings and fixed equipment. Have you considered what the impact would be on those hospitals given a policy change in hospital capital financing?

For example, what effect would the average capital cost per discharge approach have on the hospital that has recently replaced its buildings, or on the hospital that is in the process of new construction?

Response to question 2.—Yes. Every institution experiences cyclical changes in its capital expenses, and any reform in Medicare capital payment policy will hit individual hospitals at varying points in their investment cycles. For those hospitals that have recently undertaken renovation or replacement projects, an adequate transition period is especially important. Phasing in the new average capital payment rates over several years by blending them with the current facility-specific capital payments, as has been done with the current DRG payments, eases the impact of the new approach on these hospitals. The longer the transition period, and the greater the weight given to the hospital-specific portion in the early years of the transition, the less the disruption will be for hospitals with substantial new capital investments.

Senator DURENBERGER. Thank you. The hearing is adjourned.

[Whereupon, at 11:11 a.m., the hearing was adjourned.]

[By direction of the chairman the following communications were made a part of the hearing record:]

health industry
manufacturers
association
hima

1030 fifteenth street, nw • washington, dc 20005-1598
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Statement for the Record

Hearing on Medicare Capital Payments

November 8, 1985

health industry
manufacturers
association
hima

1030 fifteenth street, nw • washington, dc 20005-1598
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Medicare Capital Payments

November 22, 1985

Introduction

The Health Industry Manufacturers Association (HIMA) recognizes the general trend of prospective payment in the Medicare program and views prospective payment as a significant challenge confronting industry and the government. We agree with the statement made by Senator Durenburger when S. 1559 was introduced that "quality care is as dependent on a hospital's ability to raise capital as it is to have revenues sufficient to keep the doors open".

Medicare's prospective payment system was designed to provide incentives to hospitals to increase productivity and efficiency. If the system is changed to capture, through annual updates, all the savings resulting from these incentives, the incentives themselves will soon lose their force. Prospective payment of capital will provide incentives to make rational decisions about the timing and financing of capital projects - but only if the payment system provides for an adequate rate of return. A capital policy should also reflect Medicare's role in assuring access to quality health care for its beneficiaries. This may require special features to accommodate vulnerable groups - either hospitals that meet unique needs or new technologies that increase initial costs above the DRG payment but offer significant patient benefits, and are cost-effective in the long-run.

With these views in mind, HIMA supports a program that:

- incorporates adequate capital costs in the base used to set DRG payments; and
- establishes a transition period that would blend hospital-specific costs with national or target rates for capital according to a schedule similar to the one proposed in S. 1559.

The provider and supplier communities have had a difficult time in reaching a consensus on the elements of a Medicare capital payment policy. Certain principles, such as the need for adequate and predictable payments and a fair transition period, have emerged as critical factors. In addition, there is a need to protect innovation -- a particularly important concern for those who make long-term investments in technological development. The current capital pass-through is, in fact, something of a safety valve for the purchase of some new products. Indeed, the wide range in capital spending and the difficulty in finding an equitable solution has generated some support to continue the current capital pass-through.

Other policy analysts have argued, however, that the current policy does not give hospital managers the balanced incentives to make productive trade-offs between capital investment and operating costs. Concern is also raised about providing an incentive to finance capital using debt instead of equity since interest expenses are fully reimbursed and depreciation is based on historical rather than replacement costs.

While there is a growing consensus that capital costs should be included in the DRG price, it is important to consider the environment in which Medicare capital policy is made. The concern about the increased use and cost of debt financing needs to be considered in the context of Congressional efforts to reduce the amount of tax exempt financing available for hospital capital.

A DRG price combining both operating and capital expenses would allow hospitals to use more equity financing, but only if hospitals are able to generate DRG profits or surpluses. Additionally, a shift to prospective capital pricing is likely to increase the debt financing costs because of the increased investment risk.

Designing a New Capital Payment Policy

If capital costs are included in the DRG price, the policy must allow:

- adequate and predictable payments;
- a fair transition period; and
- protection for innovation.

1. Adequacy of Payments

Adequate capital replenishment is an essential part of assuring continued service to the Medicare beneficiaries. It is important to all hospitals, not just those with the greatest immediate need. While capital investment has stabilized in the last few years, it is not clear how much capital will be required in the future.

Moreover, Medicare capital policy cannot be considered in a vacuum since other factors will influence the hospital industry's ability to acquire and use capital. Among these factors, the growth of HMO's and other capital arrangements, alternatives to providing care outside of hospitals, a changing hospital population, and changes in the economic environment that affect the costs of capital, including policies related to return on equity, tax exempt financing, and federal mortgage loan and insurance programs.

Medicare capital policy should be designed so that hospitals are paid an adequate price to cover the costs of efficiently providing a set of services to Medicare patients and are given the ability to generate a rate of return. The policy should be designed so that Medicare's payment rates adjust to reflect changes in the economic and relevant policy environment.

2. Predictability of Payment

Predictable payments are essential to economically reasonable arrangements for capital as well as to provide badly needed reassurances to the health care community that commitments regarding the total prospective payment system will be honored.

Hospitals should be able to predict with some certainty the Medicare revenues that could be expected over a period of several years. This will require a clear statute that specifies which elements of capital costs are to be included in the base, how the base rates will be updated to reflect inflation, and any adjustments that may be made for special needs.

Any ambiguity that would result in uncertainty or conflicting interpretations would be counter-productive.

3. Fairness of a Transition Period

A fair transition is critically important, especially in the short-term. Questions about the ultimate distribution of hospitals by size and function should be addressed as the serious policy issues they are and not just absorbed into decisions about what the budget should bear during the transition period. Transitional fairness may suggest that some groups such as small rural hospitals, public hospitals, and sole community providers deserve special attention.

A transition mechanism should work toward a level playing field rather than penalizing or rewarding hospitals because of prior decisions. The transition policy should be balanced to honor Medicare's prior commitments as well as to give hospitals enough time to generate equity to fund future capital needs.

The best mechanism for assuring a fair transition is to establish a blended rate -- combining a hospital-specific component with a national rate -- that would be phased in over several years. A consensus is developing that the transition period should extend between five and seven years with the hospital-specific portion representing the majority of the payment in the early years. The transition period could conclude with a national rate or could preserve some level of hospital-specific payment.

Actual capital costs incurred by a hospital are most reflective of the cyclical nature of capital spending and could be used to set the hospital-specific rates. While this would require a continuation of some cost-reporting, HIMA believes it would be a reasonable trade-off to achieve a rational payment policy.

4. Protection for Innovation and Access

A strict Medicare capital payment policy may cause hospitals to delay acquisition of beneficial technology with long-term cost-effectiveness. To prevent that from happening, hospitals could be permitted to recover, on an interim basis, the actual capital costs of selected technologies that represent significant advances as represented by receiving premarket approval by the Food and Drug Administration. A separate program could be designed to allow hospitals, again on an interim basis, to bill for Medicare's portion of the depreciation and interest expense of new capital technology after the Food and Drug Administration has given premarket approval, but before the Health Care Financing Administration has made a decision on Medicare coverage and reimbursement.

Statement By The

NATIONAL ELECTRICAL MANUFACTURERS ASSOCIATION

To The

SUBCOMMITTEE ON HEALTH
SENATE FINANCE COMMITTEE

ON MEDICARE CAPITAL REIMBURSEMENT

November 8, 1985

The National Electrical Manufacturers Association (NEMA*) appreciates the opportunity to present its views to the Senate Finance Committee Subcommittee on Health on proposals for incorporating Medicare capital hospital payments into the prospective payment system (PPS).

Senator Durenberger, Chairman of the Subcommittee, and Senator Quayle have introduced what they called a "starter proposal," S.1559. The Acting Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services (HHS), Robert B. Helms, presented some of the Administration's concerns at the Subcommittee's hearings on November 8. While both of these positions evidence commendable assessment of the issues, they do not resolve completely the problems that need to be addressed. In response to Senator Durenberger's request and in light of his recognition that further evaluation needs to be done, NEMA asks that the Subcommittee particularly considers the issues supported in these comments.

In determining how to include capital cost into PPS, our foremost concern is that the quality of patient care Americans have benefitted from to date is ensured. We know that the Subcommittee shares this concern and recognizes that patient care has reached such high quality largely due to the remarkable progress in new medical technology. Technological success can be credited with saving many lives and improving the quality of life for many others. Hospitals must be ensured an environment where this progress will not be impeded. To secure high quality patient care, it is also important that any proposal allow hospitals the integrity of their business decisions. Only the hospitals themselves can best determine their patients' needs. Therefore, any proposal on how capital costs will be paid for must ensure that the payment is adequate and predictable and is equitable to meet the needs of individual hospitals and classes of hospitals.

Hospitals vary widely in the proportion of their budget that is tied to capital costs. Not only does the amount vary among different kinds of hospitals, but it also varies in any given year of a capital cost cycle. For example, hospitals that have difficulty getting financing, such as rural or large urban hospitals, have an above-average capital ratio. Teaching hospitals traditionally have a lower than average ratio of capital to operating costs, while Catholic hospitals have a high capital ratio and lower operating costs. This variation is magnified when the capital cost cycle is factored in to the ratio because capital decisions are long-term decisions and occur infrequently -- a hospital in need of major renovation, for example, would have below-average capital costs. Conversely, in the years immediately following a hospital's major investment, its capital costs will be much higher.

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*NEMA is the principal national trade association of the electrical manufacturing industry. The Association has some 550 member manufacturing companies, ~~which are~~ affiliated with one or more of its product Divisions, each Division representing in essence a separate and distinct industry. NEMA's Diagnostic Imaging and Therapy Systems Division represents fifty-eight manufacturers providing high technology medical devices to the health care field in the areas of conventional medical and dental x-ray imaging, computed tomography (CT) scanners, diagnostic ultrasound, nuclear imaging, radiation therapy equipment and magnetic resonance.

Both S.1559 and the Administration's proposal would base capital payments on a ratio of hospital-specific costs to a national average. The ratio would change over a period of transition into PPS until the total amount paid would be based on the national average. So that hospitals are not penalized by a change in the payment system, it is imperative that the hospital specific portion of the ratio be large enough to adequately reflect the wide variations in hospitals. Further, the transition period must be sufficiently long to move hospitals into PPS without disturbing necessary planned expenditures.

S.1559 would establish a transition period extending over five years and the Administration has indicated it will propose seven years. NEMA believes that a seven-year period is more realistic because of the need to give hospitals ample time to readjust.

S.1559 proposes to base the ratio on the average of three years, 1984-86. However, we are concerned that the base for individual hospitals in those years may be skewed in the wake of the implementation of PPS in 1983. Further, the data from those years is not yet complete, which increases our hesitancy. We fear that hospitals may have over-reacted to the change in the payment system and deferred capital expenditures because of their uncertainty about the increasing unpredictability of the PPS system in general and future capital reimbursement in particular. It therefore would be more realistic and equitable to base the hospital specific portion of the ratio on actual costs incurred by a hospital in each year of the transition. For the same reasons, consideration should be given to extending the base period for the national average to include pre-PPS years, for example 1980-85.

Because of our concern that the ratio be realistic, we also ask that whatever proposal is adopted be monitored closely to determine that hospitals' needs are being met. It will only be after hospitals have had experience with the new system that the most equitable assessment can be made.

It is also important that hospitals are ensured predictability of payments. Not only is this imperative because capital expenditures are necessarily long-term decisions, but it is also needed to ensure an environment of financial stability for hospitals.

It is basic sound business policy that a hospital should be able to plan expenditures. And it also is recognized by investors who will perceive a higher risk if hospitals can not depend on predictable payments and will impose higher interest rates.

A concept that the Administration had previously considered was to permit borrowing from future capital payments; that is to allow a hospital in years of high investment to borrow from future years in their capital cost cycle when their capital needs will be lower. We believe such a policy would be a more realistic approach than to assume that the capital cost cycle can be forever levelled after five- or seven-years transition period.

NEMA hopes that our concerns will help the Subcommittee and the Administration in formulating its final proposal. If we can be of any further assistance in this effort, we are ready to provide whatever additional information would be helpful to the Subcommittee.

UNIVERSITY OF VIRGINIA HOSPITALS
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OFFICE OF THE EXECUTIVE DIRECTOR

6 November 1985

The Honorable Bob Packwood
Chairman, Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Senator Packwood:

The proposed reduction in capital payments under the Medicare Prospective Payment System would seriously undermine the financial future of the University of Virginia Hospitals. We have undertaken a desperately needed partial replacement hospital and partial renovation of our 30 to 50 year old facilities. The Durenberger/Quayle proposal would result in a reduction in our projected capital reimbursement by more than $7 million per year. Even the alternate proposal of the Association of American Medical Colleges would reduce our capital payment by more than $6 million per year.

The history of the replacement project at the University of Virginia is most instructive. We have recognized the need to replace our entirely outmoded and inadequate physical facilities since 1975. A deliberate planning process was undertaken which resulted in the decision to build a new hospital in 1980. Site selection and preliminary financial feasibility was undertaken and completed in 1981. The final Financial Feasibility Study, Certificate of Need approval and State authorization and appropriation were obtained in 1984. We began construction of the project in June 1985. The Replacement Hospital portion of the project will be completed in the summer of 1988, and the renovation of the existing facilities will be completed in the summer of 1990. The University of Virginia is obligated to repay $135.4 million in bonded debt as part of the financing of the replacement project.

Our initial financial feasibility study, undertaken in 1983, based on the recently adopted Prospective Payment System law and regulations, indicated that the hospital could reasonably undertake a $300 million construction project. We revised that early financial feasibility study because we did not believe that Medicare and other third party payors would permit that level of capital reimbursement. Our revised financial feasibility study, undertaken by Ernst and Whinney was based on a construction project of less than $200 million which resulted from our decision to only partially replace the existing hospital, and to renovate the 30 year old portion of the existing facility.

The financial feasibility forecast which supported the June 1985 long term bond issue yielded bond ratings of A1/A+. The University's Management, the feasibility consultants, the Administration of the Commonwealth of Virginia, and the rating agencies of Moody's and Standard and Poor's accepted the replacement project scope and the financial forecast as reasonable.

Now we face the prospect of even more dramatically reduced capital payment as reflected in the Durenberger/Quayle proposal, or even by the proposal from the Association of American Medical Colleges. The attached chart shows the effect of both of these proposals. The projected losses in capital payment will seriously harm the ability of this institution to provide tertiary services, maintain its educational programs, and to remain a state-of-the-art referral center. The Commonwealth of Virginia has lower than national hospital costs, and the regions served by the University of Virginia Hospitals have average daily room charges that are $100 per day lower than the rest of the state. This reduction in hospital costs is achieved by our hospital concentrating on tertiary high-cost services and permitting the community hospitals that we cooperate with to concentrate on lower cost primary and secondary services.

The dramatic reduction in capital pass-through will have serious effect on our hospital and many other teaching hospitals in this country. I urge your Committee to develop an adequate capital payment system that can reward reasonable judgement for capital expenditure with adequate reimbursement, or, as an alternate, grandfather those insitutions who have contracted for capital projects prior to the adoption of legislation which would reduce the amount of capital costs reimbursed by Medicare.

We are prepared to share all of our financial feasibility data with your staff. We will cooperate fully with you to obtain a fair capital payment system for hospitals through the Medicare Program.

Sincerely,

John T. Ashley

John T. Ashley, M.D.
Executive Director

University of Virginia Hospitals
Impact of Medicare Capital Payment Proposals

(Dollars in Millions)

	AAMC Proposal	Durenberger/Quayle Proposal
UVAH Capital Costs 1991	$30.5	$30.5
Medicare %	30%	30%
Medicare Related Capital	$ 9.2	$ 9.2
Proposed Capital Reimbursement Assuming 7% Add-on	3.0	2.1
Reduction in Capital Reimbursement 1991	$ 6.2	$ 7.1

NOTE: Replacement Hospital to be occupied July 1988
Renovated Hospital to be completed August 1990
Total capital cost approximately $209.7 million